EXHIBIT 156

COX-2–Selective NSAIDs
New and Improved?

David R. Lichtenstein, MD
M. Michael Wolfe, MD

GASTROINTESTINAL (GI) TOXICITY INDUCED BY NONsteroidal anti-inflammatory drugs (NSAIDs) is among the most common serious adverse drug events in the industrialized world. Gastroduodenal ulcers can be demonstrated by endoscopy in 10% to 20% of patients who take NSAIDs on a regular basis, and the annual incidence of clinically important GI complications approaches 2%.[1] The impact of NSAIDs on public health is significant and has provided the impetus to search for safer but equally effective anti-inflammatory agents.

Damage to the gastroduodenal mucosa associated with use of NSAIDs occurs as a result of both the topical and systemic properties attributed to these agents.[1] The latter appears to play the predominant role, largely through decreased synthesis of mucosal prostaglandins. These compounds are ubiquitous 20-carbon molecules that are derived from the catalytic conversion of arachidonic acid via the cyclooxygenase (COX) pathway. More than a decade has elapsed since 2 related but unique COX isoforms were discovered, each encoded by a separate gene and exhibiting a discrete pattern of tissue-specific expression. COX-1 is predominantly expressed constitutively and functions as a physiologic "housekeeping" enzyme in most tissues, including the gastric mucosa, the kidneys, and platelets.[2] COX-2 expression, especially in macrophages and synovial cells, is induced by inflammation and mitogen stimulation,[3] and it has been proposed that the anti-inflammatory properties of NSAIDs are mediated through COX-2 inhibition, whereas adverse effects occur as a result of their effects on COX-1.

Traditional NSAIDs differ in their relative inhibitory potency against COX-1 and COX-2. The important role of COX-1 in protecting the gastroduodenal mucosa is supported by studies showing that the greatest degree of damage is generally caused by NSAIDs that preferentially inhibit COX-1. Although the definition and methods for assessing selectivity continue to be controversial, the World Health Organization has categorized COX-2–selective drugs as a new subclass of NSAIDs (coxibs). The 2 coxibs currently available, rofecoxib and celecoxib, maintain their anti-inflammatory properties while preserving the biosynthesis of protective COX-1–derived prostaglandins. Although rofecoxib is the more selective of the 2,[4] both agents appear to be as effective as nonselective NSAIDs in suppressing inflammation and providing analgesia, while reducing the incidence of endoscopic ulcers to levels similar to those seen with placebo.[5-7]

Previous studies examining the prostaglandin E_1 analog misoprostol have suggested a correlation between endoscopic ulcers and clinical outcomes.[8] However, it is imperative that a decrease in the clinically evident ulcer complications termed POBs (perforation, gastric outlet obstruction, and bleeding) likewise be demonstrated prior to establishing the safety of these new NSAIDs. In this issue of THE JOURNAL, Silverstein et al[9] report the results of a 6-month randomized, double-blind, controlled trial comparing the ulcerogenic potential and upper GI toxicity of celecoxib in individuals with osteoarthritis (OA) or rheumatoid arthritis (RA). The study involved 7968 patients who were randomly assigned to receive 400 mg of celecoxib twice per day (2 and 4 times the maximum RA and OA dosages approved for labeling by the US Food and Drug Administration, respectively); ibuprofen, 800 mg 3 times per day; or diclofenac, 75 mg twice per day. Baseline characteristics of the treatment groups were similar with regard to risk factors previously shown to predispose individuals to ulcer complications, including age, primary rheumatologic disorder, prior history of GI bleeding or ulcer, *Helicobacter pylori* infection, tobacco or alcohol use, and concurrent use of aspirin, corticosteroids, or anticoagulants.

The authors conclude that celecoxib at supratherapeutic dosages was associated with a lower incidence of symptomatic ulcers and ulcer complications than the comparator NSAIDs given at standard dosages. However, even though the combined incidence of symptomatic ulcers or POBs associated with celecoxib was significantly lower than with the comparator drugs, careful examination of the data shows that the rate of ulcer complications alone, the primary end point of the study, was not. The annualized incidence of POBs plus symptomatic ulcers with celecoxib was 2.08% vs 3.54%

See also p 1247.

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for patients taking ibuprofen or diclofenac ($P=.02$). The annualized incidence rates of ulcer complications alone for celecoxib and nonselective NSAIDs were 0.76% and 1.45%, respectively ($P=.09$), a trend favoring celecoxib that did not achieve statistical significance.

The annualized ulcer complication rate in the celecoxib group was substantially greater than the previously cited incidence of 0.2% to 0.4%,[4,10] which was used in the study by Silverstein et al[9] to calculate the sample size required for randomization. This increased ulcer complication rate for celecoxib can be partially attributed to the supratherapeutic dosage of celecoxib used in the study but more likely was a result of including patients taking concurrent low-dosage (≤325 mg/d) aspirin for cardiovascular prophylaxis. Of patients enrolled in this trial, 20.6% were taking low-dosage aspirin, twice the rate reported in other celecoxib clinical trials.[11] This dosage of aspirin has been shown in several previous studies to increase the risk of upper GI hemorrhage[12-14] and appears to have offset any potential protective effect of COX-2 selectivity for celecoxib in this trial. Within the celecoxib group, the relative risk of an ulcer complication was 4.5 when low-dosage aspirin was taken ($P=.01$). Moreover, for patients taking aspirin, the annualized incidence rates of POBs alone for celecoxib and nonselective NSAIDs were 2.01% and 2.12% ($P=.92$), respectively; for POBs combined with symptomatic ulcers, the rates were 4.7% and 6.0% ($P=.49$), respectively. Therefore, a small ulcer risk reduction for celecoxib among patients taking low-dosage aspirin may exist that cannot be conclusively discerned by the study due to the small number of patients taking aspirin (type II error).

In contrast, for patients not taking aspirin, the annualized incidence of POBs was significantly lower with celecoxib compared with ibuprofen and diclofenac: 0.44% vs 1.27% ($P=.04$). Similarly, the annualized incidence of ulcer complications combined with symptomatic ulcers in patients not taking aspirin was also significantly lower with celecoxib than with the comparator drugs: 1.40% vs 2.91% ($P=.02$). The ulcer complication rate in nonaspirin users who received celecoxib (0.44%) is similar to the background rate of ulcer complications observed in patients not taking NSAIDs or aspirin in the general population. Thus, because a placebo group was not included in this study, it is not possible to calculate accurately an ulcer complication risk attributable to celecoxib.

In addition, the safety of celecoxib relative to nonselective NSAIDs cannot be attributed entirely to the COX-2 selectivity of this agent. For example, COX-1–deficient mice do not develop spontaneous GI injury,[15] and the administration of a traditional NSAID produces typical mucosal lesions in these animals. Other factors, such as nitric oxide, calcitonin gene-related peptide, and trefoil peptides,[16,17] may play a critical role in maintaining gastroduodenal mucosal integrity. Such redundancy in preserving normal physiologic function is not unique, and it constitutes the rationale for the future development of potentially gastroprotective NSAID formulations that promote nitric oxide release. Furthermore, COX-2 is expressed at the borders of gastric ulcers and has been implicated as a critical factor in promoting the reparative process.[18] This issue raises the possibility that individuals with preexisting gastroduodenal ulcers who take COX-2–selective NSAIDs may be at risk for delayed ulcer healing and the potential development of a complication.

The data presented in this issue of *JAMA* by Silverstein et al[9] generally support the overall safety of celecoxib, despite the nonsignificant difference in the primary outcome measure. This COX-2–selective inhibitor was better tolerated than nonselective NSAIDs as evident from a decreased incidence of GI symptoms and lower rates of secondary study withdrawal. The decrease in GI symptoms may have resulted in fewer endoscopic evaluations in the celecoxib group and could partly account for the lower detection rate of ulcers in the group. Celecoxib was also associated with a lower incidence of clinically meaningful reductions in hematocrit, even when patients with ulcer complications, symptomatic ulcers, and other GI disease were excluded from the analysis. In theory, COX-2–selective inhibitors might increase the risk for thromboembolic cardiovascular events because of the preferential inhibition of endothelial prostacyclin synthesis without corresponding inhibition of platelet thromboxane synthesis.[19] However, the overall incidence of cardiovascular events, and specifically cerebrovascular accidents and myocardial infarction, were similar in the 2 treatment groups.

The clinical consequences of NSAIDs on renal function are heterogeneous, as the relative importance of COX-1 and COX-2 in the human kidney is not well defined.[20] Nevertheless, in the study by Silverstein et al,[9] the incidence of adverse renal events and hypertension was significantly lower in the celecoxib group than in the groups treated with ibuprofen or diclofenac. Another important question is whether coxibs in general will incite or exacerbate preexisting inflammatory bowel disease, since experimental colitis may be induced both in COX-2–deficient mice and in rats treated with COX-2–selective inhibitors.[21] That COX-2 may play other important physiologic roles is further supported by the finding that COX-2–deficient mice have demonstrated defects in renal function,[22] female reproductive physiology,[23] and regulation of bone resorption.[1] These theoretical concerns must be balanced against other potential beneficial effects of COX-2 selective inhibition. For example, enhanced COX-2 expression has been found in human colorectal neoplasia, and selective COX-2 inhibition may thereby reduce the development of colorectal and other GI malignancies.[24,25]

Although COX-2–selective NSAIDs appear to be "new and improved," they certainly are less than perfect. These agents have become and will continue to constitute a welcome addition to the therapeutic armamentarium for the treatment

of inflammatory arthritides and for analgesia. The results of this important study by Silverstein et al[9] provide promising data to suggest that celecoxib and possibly other COX-2–selective NSAIDs are effective in reducing, but not eliminating, the risk of symptomatic ulcers and ulcer complications in the enormous number of individuals who might benefit from these drugs, at least among individuals who do not take aspirin. However, because this prospective analysis was limited to 6 months, careful postmarketing surveillance and future large-scale outcome analyses of COX-2–selective NSAIDs will be required to determine their ultimate benefit and safety profile.

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EXHIBIT 157

From: Burken, Menno van
Sent: Friday, September 08, 2000 2:27 AM
To: Byer, Alicia; Ahmed, Hussein; Bahrt, Kenneth; Condon, Irene; Denton, James; Dicker, Joy; Gandelman, Mitchell; Haupt, Solveig; Leishman, Valarie; Lymburner, Jeffrey; Meppen, Michelle; Nelson, Rooney; Plofchan, Jennifer N; Prestel, Betina; Scheuer, Nazanine; Sirota, Eric; Tive, Leslie
Cc: Pena, Betty M.; Pettitt, Dan; Jelich, Vicki; Kitsis, Elizabeth; Bercetche, Martin
Subject: RE: JAMA Editorial - Confidential?

Thanks Alicia for forwarding this.

Clearly this editorial might be more important than the actual publication. It underscores some of the issues and also strengths of the data. When Jim Lefkowitz is sharing his Q&A with us (22 questions), at least the issues outlined in this editorial need to be addressed. Countries need to be trained in both pieces our study pub. AND this editorial.

Menno

-----Original Message-----
From: Byer, Alicia
Sent: Thursday, September 07, 2000 2:03 PM
To: Ahmed, Hussein; Bahrt, Kenneth; Burken, Menno van; Byer, Alicia; Condon, Irene; Denton, James; Dicker, Joy; Gandelman, Mitchell; Haupt, Solveig; Leishman, Valarie; Lymburner, Jeffrey; Meppen, Michelle; Nelson, Rooney; Plofchan, Jennifer; Prestel, Betina; Scheuer, Nazanine; Sirota, Eric; Tive, Leslie
Cc: Pena, Betty M.; Pettitt, Dan; Jelich, Vicki
Subject: FW: JAMA Editorial - Confidential?

<< File: AMAEDITO.DOC >> Team,

Below please find a copy of the upcoming JAMA editorial that I believe will be found in the Sept. 13th JAMA where the CLASS study will be published. Please do not distribute this as I am unsure if it is embargoed until publication.

Thanks,

Alicia
-----Original Message-----
From: JAMES B. LEFKOWITH at Exchange
Sent: Thursday, September 07, 2000 11:13 AM
To: Byer, Alicia; Wahba, Mona M
Subject: FW: JAMA Editorial

MICHAEL FRIEDMAN
CCR
NO.: 306

-----Original Message-----
From: SCHEFF, LISA R [FND/1820]
Sent: Thursday, September 07, 2000 8:58 AM
To: KOVITZ, CLAUDIA R. [FND/1820]; LEFKOWITH, JAMES B. [PHR/1825]
Subject: JAMA Editorial
Importance: High

Here it is!
-----Original Message-----
From: Nicole Symon [mailto:NSymon@mslpr.com]
Sent: Wednesday, September 06, 2000 7:27 PM
To: diana.e.smith@monsanto.com; lisa.r.scheff@monsanto.com; sally.b.young@monsanto.com; Celeste.torello@pfizer.com

Cc: Helen Tarleton; Tracy Vandervalk; Cristina Biro; Harold Silverman; Laura Webber; Michael Echter; MaryEllen O'Donohue; Stephanie Marchesi; Sarah Townend; Wendy Lund
Subject: AMA Editorial

COX-2-Selective NSAIDs
New and Improved?

David R. Lichtenstein, MD
M. Michael Wolfe, MD

Gastrointestinal (GI) Toxically Induced by Nonsteroidal anti-inflammatory drugs (NSAIDs) is among the most common serious adverse drug events in the industrialized world. Gastroduodenal ulcers can be demonstrated by endoscopy in 10% to 20% of patients who take NSAIDs on a regular basis, and the annual incidence of clinically important GI complications approaches 2%. The impact of NSAIDS on public health is significant and has provided the impetus to search for safer but equally effective anti-inflammatory agents.

Damage to the gastoduoudenal mucosa associated with use of NSAIDs occurs as a result of both the topical and systemic properties attributed to these agents. The latter appears to play the predominant role, largely through decreased synthesis of mucosal prostaglandins. These compounds are ubiquitous 20-carbon molecules that are derived from the catalytic conversion of arachidonic acid via the cyclooxygenase (COX) pathway. More than a decade has elapsed since 2 related but unique COX isoforms were discovered, each encoded by a separate gene and exhibiting a discrete pattern of tissue-specific expression. COX-1 is predominantly expressed constitutively and functions as a physiologic "housekeeping" enzyme in most tissues, including the gastric mucosa, the kidneys, and platelets. COX-2 expression, especially in macrophages and synovial cells, is induced by inflammation and mitogen stimulation, and it has been proposed that the anti-inflammatory properties of NSAIDS are mediated through COX-2 inhibition, whereas adverse effects occur as a result of their effects on COX-1.

Traditional NSAIDs differ in their relative inhibitory potency against COX-1 and COX 2. The important role of COX-1 in protecting the gastoduodenal mucosa is supported by studies showing that the greatest degree of damage is generally caused by NSAIDs that preferentially inhibit COX 1. Although the definition and methods for assessing selectivity continue to be controversial, the World Health Organization has categorized COX 2 selective drugs as a new subclass of NSAIDs (coxibs). The 2 coxibs currently available, rofecoxib and celecoxib, maintain their anti-inflammatory properties while preserving the biosynthesis of protective COX-1-derived prostaglandins. Although rofecoxib is the more selective of the 2, both agents appear to be as effective as nonselective NSAIDs in suppressing inflammation and providing analgesia, while reducing the incidence of endoscopic ulcers to levels of similar to those seen with placebo.

Previous studies examining the prostaglandin E, analog misoprostol have suggested a correlation between endoscopic ulcers and clinical outcomes. However, it is imperative that a decrease in the clinically evident ulcer complications termed POBs (perforation, gastric outlet obstruction and bleeding) likewise be demonstrated prior to establishing the safety of these new NSAIDs. In this issue of THE JOURNAL, Silverstein et al report the results of a 6-month randomized, double-blind, controlled trial comparing the ulcerogenic potential and upper GI toxicity of celecoxib in individuals with osteoarthritis (OA) or rheumatoid arthritis (RA). The study involved 7,968 patients who were randomly assigned to receive 400 mg of celecoxib twice per day (2 and 4 times the maximum RA and OA dosages approved for labeling by the US Food and Drug Administration, respectively); ibuprofen, 800 mg 3 times per day; or diclofenac, 75 mg twice per day. Baseline characteristics of the treatment groups were similar with regard

to risk factors previously shown to predispose individuals to ulcer complications, including age, primary rheumatologic disorder, prior history of GI bleeding or ulcer, Helicobacter pylori infection, tobacco or alcohol use, and concurrent use of aspirin, corticosteroids, or anticoagulants.

The authors conclude that celecoxib at supratherapeutic dosages was associated with a lower incidence of symptomatic ulcers and ulcer complications than the comparator NSAIDs given at standard dosages. However, even though the combined incidence of symptomatic ulcers or POBs associated with celecoxib was significantly lower than with the comparator drugs, careful examination of the data shows that the rate of ulcer complications alone, the primary end point of the study, was not. The annualized incidence of POBs plus symptomatic ulcers with celecoxib was 2.08% vs. 3.54 % for patients taking ibuprofen or diclofenac (P£ .02). The annualized incidence rates of ulcer complications alone for celecoxib and nonselective NSIDS were 0.76% and 1.45%, respectively (P = .09), a trend favoring celecoxib that did not achieve statistical significance.

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In contrast, for patients not taking aspirin, the annualized incidence of POBs was significantly lower with celecoxib compared with ibuprofen and diclofenac: 0.44% vs. 1.27% (P = .04). Similarly, the annualized incidence of ulcer complications combined with symptomatic ulcers in patients not taking aspirin was also significantly lower with celecoxib than with the comparator drugs: 1.40% vs. 2.91% (P= .02). The ulcer complication rate in nonaspirin users who received celecoxib (0.44%) is similar to the background rate of ulcer complications observed in patients not taking NSAIDs or aspirin in the general population. Thus, because a placebo group was not included in this study, it is not possible to calculate accurately an ulcer complication risk attributable to celecoxib.

In addition, the safety of celecoxib relative to nonselective NSAIDs cannot be attributed entirely to the COX-2 selectivity of this agent. For example, COX-1-deficient mice do not develop spontaneous GI injury, and the administration of a traditional NSAID produces typical mucosal lesions in these animals. Other factors, such as nitric oxide, calcitonin gene-related peptide, and trefoil peptides, may play a critical role in maintaining gastroduodenal mucosal integrity. Such redundancy in preserving normal physiologic function is not unique, and it constitutes the rationale for the future development of potentially gastroprotective NSAID formulations that promote nitric oxide release. Furthermore, COX-2 is expressed at the borders of gastric ulcers and has been implicated as a critical factor in promoting the reparative process. This issue raises the possibility that individuals with preexisting

gastroduodenal ulcers who take COX-2-selective NSAIDs may be at risk for delayed ulcer healing and the potential development of a complication.

The data presented in this issue of JAMA by Silverstein et al generally support the overall safety of celecoxib, despite the nonsignificant difference in the primary outcome measure. This COX-2 - selective inhibitor was better tolerated than nonselective NSAIDs as evident from a decreased incidence of GI symptoms and lower rates of secondary study withdrawal. The decrease in GI symptoms may have resulted in fewer endoscopic evaluations in the celecoxib group and could partly account for the lower detection rate of ulcers in the group. Celecoxib was also associated with a lower incidence of clinically meaningful reductions in hematocrit, even when patients with ulcer complications, symptomatic ulcers, and other GI disease were excluded from the analysis. In theory, COX-2-selective inhibitors might increase the risk for thromboembolic cardiovascular events because of the preferential inhibition of endothelial prostacyclin synthesis without corresponding inhibition of platelet thromboxane synthesis. However, the overall incidence of cardiovascular events, and specifically cerebrovascular accidents and myocardial infarction, were similar in the 2 treatment groups.

The clinical consequences of NSAIDs on renal function are heterogeneous, as the relative importance of COX-1 and COX-2 in the human kidney is not well defined. Nevertheless, in the study by Silverstein et al, the incidence of adverse renal events and hypertension was significantly lower in the celecoxib group than in the groups treated with ibuprofen or diclofenac. Another important question is whether coxibs in general will incite or exacerbate preexisting inflammatory bowel disease, since experimental colitis may be induced both in COX-2-deficient mice and in rats treated with COX-2-selective inhibitors. That COX-2 may play other important physiologic roles is further supported by the finding that COX-2 - deficient mice have demonstrated defects in renal function, female reproductive physiology, and regulation of bone resorption. These theoretical concerns must be balanced against other potential beneficial effects of COX-2 selective inhibition. For example, enhanced COX-2 expression has been found in human colorectal neoplasia, and selective COX-2 inhibition may thereby reduce the development of colorectal and other GI malignancies.

Although COX-2 - selective NSAIDs appear to be "new and improved," they certainly are less than perfect. These agents have become and will continue to constitute a welcome addition to the therapeutic armanamentarium for the treatment of inflammatory arthritides and for analgesia. The results of this important study by Silverstein et al provide promising data to suggest that celecoxib and possibly other COX-2-selective NSAIDs are effective in reducing, but not eliminating, the risk of symptomatic ulcers and ulcer complications in the enormous number of individuals might benefit from these drugs, at least among individuals who do not take aspirin. However, because this prospective analysis was limited to 6 months, careful postmarking surveillance and future large-scale outcome analyses of COX-2 selective NSAIDs will be required to determine their ultimate benefit and safety profile.

EXHIBIT 158

From: CETERA, PASQUALE [PNU/USCHQPO3]
Sent: Wednesday, October 25, 2000 3:11 PM
To: HOPKINS, ANNE M [PHR/5430]
Cc: NUGENT, MARILYN E [PHR/5430]; HERTERICH, ROLAND [PHR/5287]; BEGLEY, WINIFRED M. [FND/1825]; FORREST, DAVID [PNU/GBMKEPO1]; WOLF, NEIL [PNU/USCHQPO1]
Subject: CBX-0280215_RE: Celebrex EU SPC and CLASS

Anne,
thank you for your comments. We have discussed in the past few days this issue and there is an agreement to follow your recommendation and do not submit a Type II variation.
However, in the meantime, a "review" document is being prepared by our

R&D colleagues to be submitted to the FDA to further clarify/support the safety of Celebrex and the differences from NSAIDs as well as Vioxx. My recommendation is that when this "whitepaper" will be available, we should regroup and discuss what regulatory strategy we want to develop in Europe. I tend to believe that this final document will offer a better understanding of our opportunities than just the CLASS study report.
Thanks again
Pasquale

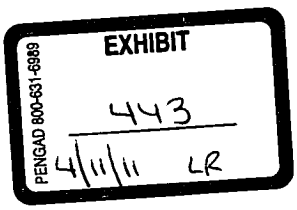
_____ Reply Separator
_____
Subject: RE: Celebrex EU SPC and CLASS
Author: ANNE M HOPKINS at Exchange
Date: 10/25/00 8:34 AM

Pasquale, thank you for sending the draft from Jim, I had not seen it before.

My response became rather long!

I assume this is the draft addendum to an expert report that Jim was working on.
After discussion with the Swedish agency we agreed to submit CLASS without an
addendum to the expert report. I do not really find the document provides much
more transparency or explanation to the original internal study report.

Topline CLASS results provide positives and negatives. On the positive side it
clearly shows no signal for cardiovascular risk - the reason for our undertaking
to provide it. On the negative side the UGI event rates are higher than in the
original controlled studies and statistical significance vs comparators is only
achieved by selection and combining of data. There is the high focus on aspirin
co-use which is prevalent in the group treated with the product. There is the
confounding factor of the dose which is supratherapeutic. There is also



the
environment - whether we like it or not - the perception of the
regulators that
COX2 science continues to evolve and is it really proven that there is
no COX1
effect at higher doses.(Need to take account that regulators take the
conservative approach and the UK MCA at the recent valdecoxib meeting
said -
there is still a question mark as to whether coxibs do have a safer GI
profile -
this may well be driven by rofecixib PMS data but it indicates where
they start
from).
Currently our strategy is that CLASS is a safety study which shows no
new safety
concerns and therefore requires no change to SPC. However we need to
prepare for
a different position being taken by the regulators since we do decsribe
data at
a 400bd dose in our SPC at the moment.

Overall I have a number of reservations about some of the statements
made in the
document.

One example, the draft document states that the CLASS study results
establish
conclusively that celecoxib is associated with a significantly lower
incidence
of symptomatic ulcers and ulcer complications than NSAID comparators -
this is a
very absolute statement. I do not see how the data support this
statement or
other similar ones. Statistical significance is only achieved when
selecting
and/or combining results eg when selecting non-aspirin takers for
serious events
and comparing celecoxib with the NSAID groups combined at the 6 month
time point
or when combining serious GI events with GD ulcers in all patients at 6
months
vs ibuprofen or NSAID combined. The study also only looked at
symptomatic
patients, when such events may be asymptomatic, not discussed.

The primary objective of the CLASS study was to compare the incidence of

clinially significant UGI adverse events, a composite safety endpoint
comprised
of perforation, bleeding or gastric outlet obstrution. Incidence of GD
ulcers
would fall into a secondary objective, yet the study report and
publication
report combined figures for serious events and ulcers. There is nothing
wrong
with combining but the numbers of serious events was so low that we did
not
reach the study endpoint, therefore alone the data are not so robust and
the
actual percentage incidence for both the serious GI events and the
ulcers is
quite a lot higher than we saw across the previous controlled studies,
albeit

that these were not sepcifically looking at the serious events in these. ? Is
there a dose effect after all??? How will this affect the SPC? There is no
discussion as to why - eg no endoscopy in CLASS etc

I know Jim does not understand why we have concerns in Europe in relation to the
potential impact of CLASS on our SPC. And I don't beleive that we have propoerly
consolidated our position of concerns across EU. The meeting we had here was not
the most appropriate forum to properly discuss these. Clearly we need to fully
explore these implications so that we have fully reasoned information to

suppport our posiiton when the time comes to meet with the agency. CLASS study
is not without its biases and a statistical nightmare. Fundamnetally the EU
regulators will not take CLASS at face value they will want sound explanations
for any selections or combining that we have done in stats analyses, for example
we have combined data from 2 studies; can we really refer to 'NSAIDs' when there
were only 2 comparators and in the rest of the study data on the SPC we name
individual NSAID etc

I beleive we must start with why we undertook to provide the CLASS study report
- i.e. to provide reassurance that there was no problem with cardiovascular
safety - and CLASS does support this, there are no new safety signals and also
no evidence of increased thrombotic events. However the dose of celecoxib in
CLASS is 400bd - double the maximum recommended, so there could still be a
question how does this therefore relate to therapeutic use at lower doses
(potential to revive the COX 1 effect at higher doses aspect). I hope that
SUCCESS which uses therapeutic doses will address this dose question and

although a shorter study will also show no particular safety signals.

Of course CLASS provides a lot of other information and its in this area we need
to agree our psoition. We have to decide what we want in relation to aspirin on
which there is a lot of focus in CLASS analyses and public domain in the JAMA
publication. I would want to look at all aspirin co-use across all the studies
and doses of celecoxib. Accepting that aspirin is an independent risk factor for
GI events we still wish to retain our differentiation from conventional NSAID in
the SPC, and rofecoxib, obviously reflecting the evidence bearing in mind that
our patient group will include aspirin takers.

To my mind CLASS raises the matter of risk factors for GI events and it

is
suggested in the draft document that in this regard celecoxib is no
different to
other NSAID, so GI history is a risk factor - I would like to thoroughly
explore
this, again across all doses of celecoxib and all the data. Again
differentiation from conventional NSAID. CLASS only looked at
symptomatic
patients yet for many years we have been saying that most serious events
are
asymptomatic, indeed until CLASS in the US label we stated (and still do
till
CLASS is assessed by FDA) that 'Only one in five patients who develop a
serious
upper GI adverse event on NSAID therapy is syptomatic' Perhaps this fact
that we
looked only at syptomatic patients has bearing on the findings. There is
no
discusssion of this aspect in the draft.

I don't want to minimalise the undertaking of doing the CLASS study but
in my
view at best CLASS, as a safety study, which is what it was, raises no
new
safety signals. The study is complicated by the fact that the dose of
celecoxib
used is double the max recommended(FDA imposed it) therefore what
meaning do
the findings have for therapeutic use particularly in the minds of the
regulators who are not so ready to just see safety at double the dose
(indeed
this is just what the German agency does not want to see - they don't
want
doctors to feel secure enough to increase the dose beyond 400 a day
max). The
doses of the comparators are in my view inconsistent for Europe i.e.
diclo 75 bd
is on the whole a commonly used therapeutic dose, ibu 2400 day is
probably
double that generllay used in EU.

Tolerabilty data are of course favourable to celecoxib but we cannot
argue a
400bd dose is supratherapeutic on the one hand for some data and yet use
it to
our benefit on the other.

These are my thoughts, regards, Anne

-----Original Message-----
From: CETERA, PASQUALE [PNU/USCHQPO3]
Sent: 10 October 2000 00:27
To: HOPKINS, ANNE M [PHR/5430]
Cc: FORREST, DAVID [PNU/GBMKEPO1]
Subject: FW: Celebrex EU SPC and CLASS

Anne,
have you seen the attached documents from Jim? Any comment?
Pasquale

_____ Forward Header

Subject: FW: Celebrex EU SPC and CLASS
Author: JAMES B. LEFKOWITH at Exchange
Date: 10/8/00 3:21 PM

Pasquale-
I think that part of the reason for the negative response is a fundamental lack
of understanding of CLASS. I have attached an early draft of an expert analysis
or report which may make things clearer to you and your colleagues.
Nonetheless, I understand that the EU is not the US. If there is a lack of
enthusiasm in the EU regarding amending the SPC, we can surely provide more
manuscripts from this study which you can use commercially. Non-Resp.

Non-Resp.

JL

-----Original Message-----
From: CETERA, PASQUALE [PNU/USCHQPO3]
Sent: Sunday, October 08, 2000 2:46 PM
To: LEFKOWITH, JAMES B. [PHR/1825]; WOLF, NEIL [PNU/USCHQPO1]
Subject: RE: Celebrex EU SPC and CLASS

Neil, Jim,
this is one example of the negative response of our colleagues in Europe about the submission of CLASS data.
As I said, it seems that we significant risks
Pasquale

_____ Forward Header

Subject: RE: Celebrex EU SPC and CLASS
Author: MARCO RENOLDI at Exchange
Date: 10/8/00 8:15 AM

Dear Roland,

given the limited time available and concomitant engagements (people travelling
etc) please find attached consolidated feedback from the following functions:
arthritis franchise (Searle Business Unit), medical department (arthritis lead),
HEAT-pharmacoeconomic affairs. We trust the same request was sent by Marylin to
her regulatory contacts in the different affiliates. Anyhow, I am copying
regulatory affairs and business development colleagues on this reply.

The general comment was we should NOT attempt submitting a Type II variation
based on the CLASS study data as the probable risks in Europe outweigh any
potential advantages, in particular the risk that a negative statement regarding
concomitant use with aspirin is introduced is deemed very high, which

might have
very serious consequences on the profiling and positioning of our compound.
Also, if - as it appears likely - we were requested to describe the CLASS data
by differentiating between ASA and non-ASA users we may have to include in our
SPC a statement whereas in patients taking celecoxib and low-dose ASA no

statistical difference was observed between celecoxib and comparative NSAIDs in
the rate of symptomatic ulcers and ulcer complications, which is something we
would have a hard time selling to our customers.
Moreover, despite the CLASS study shows an advantage over conventional NSAIDs
regarding the incidence of [redacted] which might lead to a rewording of the side-effects
paragraph (these adverse events would be considered as "common" rather than
"uncommon" as they are today).

Hope this helps. By means of this email I also invite my regulatory colleagues
to forward to Roland any additional input on the matter (I understand the new
deadline is Tuesday).

Best regards,

Marco Renoldi
Team Leader, Searle Division
Pharmacia MCI

-----Original Message-----
From: HERTERICH, ROLAND [PHR/5287]
Sent: venerdì 6 ottobre 2000 17.24
To: RENOLDI, MARCO [PHR/6073]; GOETZ, MARKUS [PHR/6015]; FORREST, DAVID
[PNU/GBMKEPO1]; DELEUZE, CHRISTIAN [PHR/5160]
Cc: CETERA, PASQUALE [PNU/USCHQPO3]; NUGENT, MARILYN E [PHR/5430]
Subject: RE: Celebrex EU SPC and CLASS
Importance: High

All,

you have received this e-mail a couple of days ago.

We really want you input on your assessment regarding
- potential risks
- potential benefits
when submitting and discussing the CLASS results with the MPA.

We would like to get your perspective on potential wording, improvements in the
SmPC. We do not want to miss any opportunity when discussing with the authorities.

I am glad if you come back with your perspective by Thursday, October 12.

Thanks and regards
Roland

-----Original Message-----
From: HERTERICH, ROLAND [PHR/5287]
Sent: Dienstag, 3. Oktober 2000 19:47
To: RENOLDI, MARCO [PHR/6073]; GOETZ, MARKUS [PHR/6015]; FORREST, DAVID
[PNU/GBMKEPO1]; DELEUZE, CHRISTIAN [PHR/5160]
Cc: CETERA, PASQUALE [PNU/USCHQPO3]; NUGENT, MARILYN E [PHR/5430]
Subject: FW: Celebrex EU SPC and CLASS
Importance: High

All,

please have a look on the communication below regarding CLASS submission to MPA.
We would like to get your input on commercial assessment regarding the most
probable changes in the SmPC.

If you can send your feedback by end of the week, it would be very much appreciated.

Thanks and regards
Roland

-----Original Message-----
From: NUGENT, MARILYN E [PHR/5430]
Sent: Dienstag, 3. Oktober 2000 11:00
To: CETERA, PASQUALE [PNU/USCHQPO3]; HERTERICH, ROLAND [PHR/5287]
Cc: HOPKINS, ANNE M [PHR/5430]
Subject: Celebrex EU SPC and CLASS

Dear Pasquale and Roland

US colleagues are pushing us to submit a Type II variation to add a statement in
the EU Celebrex SPC regarding the results from CLASS. We are taking a cautious
approach because by submitting this variation all EU agencies will be involved
in reviewing the CLASS data and there may be some detrimental effects on

existing statements regarding concomitant use with aspirin.

I prepared the attached table to give an idea of best case/worst case scenarios
for the SPC. Unlike the US labelling, we will not be able to describe the CLASS
results in great detail and are likely to be confined to a few sentences in
section 5.1. We expect that we will not be able to lump together the NSAID
results and will have to talk about significance versus individual NSAIDs, so
this will confine us to mention ibuprofen only since results vs diclofenac did
not reach significance. Although in my best case scenario in 5.1. I have a
sentence explaining why no signif difference was seen vs diclo I think that this
won't be allowed. There is also a danger that we might lose the present

positive
short-term statement regarding diclo,ibu and naproxen comparators - they may
argue that the diclo statement here is not valid since a longer term study
showed no dfference vs diclo.

My biggest worry is that we will have to amend the advice that we give regarding
use with low dose aspirin and even go so far as to say that Celebrex should not
be used with aspirin.

I do not want to arrange a meeting to discuss CLASS with the MPA without first
having the go-ahead from EU commercial. I would be grateful for your assessment
of the commercial risk, do you think that this is something that we should be
pursuing for the SPC?

Best wishes

Marilyn

EXHIBIT 159

DRAFT – FOR INTERNAL REVIEW ONLY
May 18 2:00 pm Incorporates first round of RAC edits
CE19836M
Media Contact: Claudia Kovitz, 847-581-6786
Investor Contact: Craig Tooman, 908-901-8853

FOR IMMEDIATE RELEASE

FINDINGS FROM CELEBREX® SAFETY STUDY SHOW TRADITIONAL NSAID COMPARATORS CAN CAUSE SERIOUS GI COMPLICATIONS WITHIN FIRST DAYS OF TREATMENT

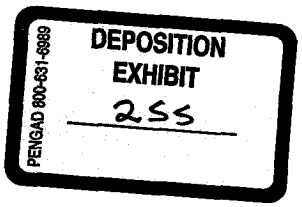
No increased risk of GI complications for H. pylori positive patients on Celebrex

SAN DIEGO, May 23, 2000 – New data from a long-term safety study presented during Digestive Disease Week (DDW) revealed that the risk for serious gastrointestinal complications with the NSAID comparators ibuprofen and diclofenac can start within the first few days after treatment begins. Further, study patients who were *H. pylori* positive had a two times greater risk of developing both symptomatic ulcers and ulcer complications when taking the NSAID comparators than *H. pylori* negative patients. No such increase was shown with patients taking Celebrex® (celecoxib capsules), regardless of *H. pylori* status.

"This study reinforces what gastroenterologists have always suspected – that even short term therapy carries risks. Many physicians feel that patients requiring short-term administration of traditional NSAIDs are not at risk for a serious gastrointestinal event. These results tell a different story, highlighting that many of the events caused by traditional NSAIDs occurred within the first few weeks, said Jay Goldstein, Associate Director of Medicine at the University of Illinois at Chicago and Chairman of the GI Events committee of the Celebrex long-term arthritis safety study, who presented the findings at a satellite symposium sponsored by Searle and Pfizer Inc during DDW.

The Celecoxib Long-term Arthritis Safety Study, an approximately 13-month, multi-center, randomized, double-blind outcomes trial of about 8,000 arthritis patients – 5,800 with OA and 2,200 with rheumatoid arthritis (RA) – was designed to mirror everyday clinical practice by enrolling a broad spectrum of patients, including adult patients of all ages and disease severity, and patients taking low-dose aspirin for cardioprotection. The study, designed to obtain a rigorous assessment of Celebrex safety, compared four times the recommended OA dose of Celebrex (800 mg daily) to typical daily doses of ibuprofen (2400 mg daily) and diclofenac (150 mg daily). The Celebrex study dose is twice the highest recommended RA dose.

Impact on Required Medical Care Studied



Under the "real-world" conditions of the study, significant decreases in the use of medical resources were shown in the Celebrex group versus the other NSAIDs studied. Sixteen percent of patients on usual doses of the NSAID comparators required office visits for blood work and evaluation versus 12.6 percent of Celebrex patients taking four times the recommended OA dose. Twenty percent of these patients were referred to a specialist, most requiring endoscopy and a complex medical work-up. This amounted to 25 percent fewer office visits and complex work-ups for patients taking Celebrex. "This is an important finding with respect to the increased burden on our medical system and the healthcare resources needed to treat these patients – especially given the finding that serious complications can occur early in treatment," noted Dr. Goldstein.

New Treatment Withdrawal Findings

Withdrawal from the study due to GI symptoms for patients on Celebrex versus traditional NSAIDs was also assessed in the trial. Tolerability data was presented that indicate diclofenac patients had a more difficult time remaining on treatment due to increases in moderate to severe GI symptoms. Significantly more patients on diclofenac were forced to withdraw from treatment as a result of these side effects. Significantly more patients on ibuprofen were forced to withdraw from treatment due to lack of efficacy. Improved tolerability suggest that patients are able to stay on therapy longer with Celebrex to achieve effective relief of pain and inflammation.

In addition, the study found that patients on Celebrex experienced significantly fewer ulcer complications compared with ibuprofen and diclofenac among non-aspirin users. Patients who needed aspirin were allowed to participate in this study since a large number of patients with arthritis take low-dose aspirin for cardioprotection, as did one-in-five patients in this study. Excluding aspirin patients from the analysis, however, offers a clearer picture of the impact of Celebrex on GI safety since aspirin is an independent risk factor for GI complications. These patients experienced three-fold fewer (64 percent) ulcer complications, a statistically significant difference from the NSAID comparators. When patients taking aspirin for cardioprotection were added to the analysis, those on Celebrex experienced two-fold fewer ulcer complications versus the traditional NSAID comparators, narrowly missing statistical significance.

Blood Loss Data has Broader Implications

As reported, study data show that there was an increased incidence of blood loss – equivalent to two pints or more – among patients on the NSAID comparators versus Celebrex, even among those without

bleeding ulcers. The rate of blood loss with Celebrex was 2.1. The rate of blood loss with placebo in the original Celebrex clinical trials was 1.8.

Importantly, the lower incidence of GI blood loss has implications for a patient's overall health, Dr. Goldstein noted. Chronic GI blood loss, which often goes undetected, can result in anemia. Less total blood in the body means less oxygen is circulating through the body. To compensate, a patient's heart must work harder and faster to pump more blood through the system. Left untreated, anemia can exacerbate underlying coronary artery disease and precipitate heart attacks and heart failure.

According to Dr. Goldstein, "Blood loss of this kind is often difficult to pinpoint. When discovered, however, patients may be forced to discontinue treatment, thereby preventing them from getting effective relief from their arthritis symptoms. Obviously we'd prefer to avoid such an outcome."

[redacted] Non-Resp. [redacted] Non-Resp. Seventy percent of the aspirin group and 50 percent of non-aspirin users had cardiovascular risk factors such as hypertension, high cholesterol, tobacco use and a history of heart attacks. [redacted] Non-Resp. [redacted] Non-Resp. [redacted]

Celebrex is not a substitute for low-dose aspirin used for cardioprotection.

Patients who have a known allergic reaction to celecoxib, certain sulfa drugs called sulfonamides, aspirin or NSAIDs, or who are in their third trimester of pregnancy should not use Celebrex. As with all NSAIDs, serious GI tract ulcerations can occur without warning symptoms. Physicians and patients should remain alert to the signs and symptoms of GI bleeding. As with all NSAIDs, Celebrex should be used with caution in patients with fluid retention, hypertension, or heart failure. The most common side effects of Celebrex were dyspepsia, diarrhea and abdominal pain, which were generally mild to moderate.

Celebrex is co-promoted by Searle, now part of Pharmacia Corporation, and Pfizer Inc. Pharmacia Corporation (NYSE:PHA) is a leading global pharmaceutical company created through the merger of Pharmacia & Upjohn with Monsanto Company and its G.D. Searle unit. Pharmacia has a broad product portfolio, a robust pipeline of new medicines, and an annual investment of more than $2 billion in pharmaceutical research and development.

Pfizer Inc (NYSE: PFE) is a research-based, global pharmaceutical company that discovers, develops, manufactures and markets innovative medicines for humans and animals. The company reported

revenues of more than $16 billion in 1999 and expects to spend about $3.2 billion on research and development this year. For more information on Pfizer, access www.pfizer.com.

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For complete prescribing information on Celebrex, access www.celebrex.com or call toll-free 888-735-3214.

EXHIBIT 160

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
CASE NO. 03-1519 (AET)

ALASKA ELECTRICAL PENSION FUND, et al., On Behalf of Themselves and All Others Similarly Situated,

Plaintiffs,

VS.

PHARMACIA CORPORATION, et al.,

Defendants.

VIDEOTAPED DEPOSITION OF PHILIP NEEDLEMAN
New York, New York
Wednesday, December 8, 2010

Reported by:
Robert X. Shaw, CSR
CSR NO. 817
JOB NO. 315763

December 8, 2010
9:15 a.m.

Deposition of PHILIP NEEDLEMAN, held at the offices of Cadwalader Wickersham & Taft LLP, One World Financial Center, New York, New York 10281, pursuant to Notice, before Robert X. Shaw, CSR, a Notary Public of the State of New York.

A P P E A R A N C E S:

MOTLEY RICE LLC
Attorneys for Plaintiffs
28 Bridgeside Blvd.
Mt. Pleasant, S.C. 29464
BY: LANCE V. OLIVER, ESQ.
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Attorneys for Plaintiffs
707 Broadway, Suite 1000
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ROBBINS GELLER RUDMAN & DOWD LLP
Attorneys for Plaintiffs
655 West Broadway
San Diego, Ca. 92101
BY: LUCAS OLTS, ESQ.

A P P E A R A N C E S (Contd):

CADWALADER WICKERSHAM & TAFT LLP
Attorneys for Defendants
One World Financial Center
New York, New York 10281
BY: JONATHAN HOFF, ESQ.
JARED S. SUNSHINE, ESQ.
212.504.5739

ALSO PRESENT:
John Proko, Videographer

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THE VIDEOGRAPHER: Please stand by.
This is tape number 1 of the videotaped deposition of Philip Needleman in the matter of Alaska Electrical Pension Fund v. Pharmacia Corporation, being heard before the United States District Court of New Jersey, Case File 03-1519.
This deposition is being held at One World Financial Center, New York, New York on December 8th, 2010 at approximately 9:12 a.m.
My name is John Proko, and I am the videographer. The court reporter is Robert Shaw.
Counsel, will you please introduce yourselves and affiliations, and the witness will be sworn.
MR. OLIVER: Lance Oliver, with the law firm of Motley Rice, for the Plaintiffs.
MR. MONTGOMERY: Matthew Montgomery with Scott and Scott, for the Plaintiffs.

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MR. OLTS: Lucas Olts, Robbins Geller, for the Plaintiffs.
MR. HOFF: Jonathan Hoff, Cadwalader Wickersham & Taft, for the Defendants.
MR. SUNSHINE: Jared Sunshine, Cadwalader Wickersham, for the Defendants.
THE WITNESS: Philip Needleman.
P H I L I P N E E D L E M A N, having been first duly sworn by the Notary Public, testified as follows:
THE WITNESS: I do.
EXAMINATION BY
MR. OLIVER:
Q. Mr. Needleman, can you just state your name for the record.
A. Philip Needleman.
Q. What's your current address?
A. 326 New Salem Drive, Creve Coeur, St. Louis, a suburb of Missouri, 63141.
Q. Are you currently employed?
A. Yes.
Q. What is your job?
A. I am president of the Donald

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Danforth Planned Sciences Institute.
Q. Is that affiliated with a university?
A. It's a private research institute.
Q. Is it a nonprofit?
A. Yes.
Q. Are you here in your official capacity or your personal capacity?
A. I'm here because I'm subpoenaed.
Q. And you're represented by counsel?
A. Yes.
Q. Your counsel is Mr. Hoff?
A. Yes.
Q. Have you ever been deposed before?
A. Yes.
Q. So, you're aware that there are some ground rules that we'd like to follow in these depositions?
A. Yes.
Q. I'd like to go over those, if you wouldn't mind, as a formality.
A. Please do.
Q. Please answer audibly. Can you agree to do that?
A. Ah, maybe.

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Q. Do your best, then, under the circumstances.
A. That's a fair approximation.
Q. No head nods, unless you're physically unable to do anything else.
If you will, please wait until the question I'm asking is finished, and I'll do you the same courtesy, and I will wait until your answer is finished before I start a new question. Can we agree to that?
A. Yes.
Q. If you don't understand a question, will you agree to ask me to repeat it?
A. Yes.
Q. And would you agree that if your lawyer objects, you may still respond to the question?
A. That's my choice.
Q. Well, we may have to talk about that later. Unless he instructs you not to answer, will you agree to answer the question?
A. Yes.
Q. Thank you.
Are you on any medications today or

do you have any physical conditions that impair your ability to answer truthfully and completely?

A. No.

(Needleman Exhibit 231, deposition notice, marked for identification as of this date.)

Q. I'd like to show you what's going to be Exhibit 231.

Actually, let me give you a clean copy here.

Do you recognize this document as your deposition notice?

A. I'll have to look at it.

(Pause.)

A. They spelled my name wrong. One L. We didn't start on time.

Q. Other than those minor issues, do you recognize this as your deposition notice?

A. I recognize this as a deposition notice. I don't know that I've seen it before.

Q. But you do understand that that's the document that brought you here today?

A. Yes.

Q. All right.

Doctor, you said you'd been deposed before.

Can you tell me the cases in which you've been deposed, briefly?

A. There was a patent case with the University of Rochester.

There was a similar case with Brigham Young University.

Many years ago there was a case with a contractor for the conduct of an Alzheimer's trial.

And then there was the case involving Celebrex and Bextra, which was a complex state case. That was about a year and a half ago.

So, that's the four or five cases.

Q. The Celebrex and Bextra litigation that you were referring to, was that a products liability case?

A. I don't know if I would call it products liability.

There was a lot of questions at those times about the side effects of Vioxx and how they influence the case, and there

was a lot of litigations of Merck and the small spillover of Celebrex and Bextra.

Q. Were any of the other cases you mentioned, or do any of the other cases you mentioned involve Celebrex?

A. They all do.

Q. Are they still pending?

A. The Celebrex Bextra was settled by Pfizer. The Rochester case was thrown out by the judge.

The BYU case, I think, is tentatively going to a jury trial in September, 2011.

I don't know whatever happened about the Alzheimer contract case. I never heard about it again.

Q. Are you a named defendant in the BYU case?

A. Explain to me the difference between being subpoenaed and being the defendant.

Q. In this case you understand that you are not a defendant?

A. So, I think that would apply to the others, too.

Q. Okay. Did you do anything to prepare for today's deposition?

A. Yes.

Q. What did you do to prepare?

A. We met yesterday, and I was re-familiarized, especially with dates, because this happened --

MR. HOFF: You don't have to describe the content of the discussion.

THE WITNESS: Yes.

MR. HOFF: He is asking just what you did, generally.

Q. Sir, you said "we met." Who is "we"?

A. My attorney, and also Joshua Weiss.

Q. Was there anybody else there?

A. No.

Q. How long did you meet?

A. Um, from 10 to about 4 yesterday.

Q. Did you review any documents?

A. Yes.

Q. How many documents?

A. Who knows. Um, one to two dozen.

Q. They all fit in one banker's box?

A. What's a worn banker's box?

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Q. One. Did they all fit in one box like this?
A. Less than that, but they were bound notebooks.
Q. Can you generally describe for me what you reviewed, the content?
A. The issue is, especially for me, is familiarizing myself especially about --
MR. HOFF: Move to strike.
I'm going to instruct you not to discuss the content.
What he wants to know is what documents you used and I think the way he asked the question in terms of what content, is just to give him an idea of, if you can, identify the specific document, the type of document it was; is that fair?
Is that what you're getting at?
Because I don't want -- if you're asking him to discuss the content of the discussions we had, then I'm going to direct him not to answer.
MR. OLIVER: I'm not asking for the content of the discussions.

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MR. HOFF: Okay.
MR. OLIVER: I just want to know the type of documents he reviewed.
MR. HOFF: He just wants to know the type of documents you looked at. You can tell him that.
A. There was the label that was finally produced by the FDA.
There was some of the slides that was the presentation at the FDA.
There was the JAMA article. Those are kind of the main things, and things related to that.
Q. Before yesterday's meeting, had you personally searched for any documents, yourself, in order to produce them in this case to the Plaintiffs?
A. No, I didn't
Q. Did your attorneys do that kind of search for you?
A. You'll have to ask them.
Q. Were you asked to destroy anything or hide anything before today's deposition?
A. No.
Q. Prior to today's deposition, other

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than your attorneys in yesterday's meeting, had you talked to any other person who was involved with this case?
A. I was called by Goran Ando from Europe.
Q. When was that?
A. A few weeks ago.
Q. Was it November 10th, 2010?
A. I don't remember the date.
Q. Does that sound close to when it probably was?
A. Well, that's a few weeks ago.
Q. How many times did you talk to Dr. Ando?
A. Once.
Q. Was that before his deposition?
A. Yes.
Q. What did you talk about?
A. The only question he had was, um, about the trial design of the CLASS trial.
Q. What was his question about the trial design?
A. Um, he wasn't clear about, um, the end-point determination.
Q. What wasn't he clear about?

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A. Um, he really wasn't actively involved in the trial, and didn't know that it was an event-driven trial instead of a time-driven trial.
Q. Did you talk to him about anything else?
A. I think that was the main point.
Q. Were there any other minor points that you can remember?
A. He was asking me how I was doing.
Q. Did you tell him you were doing well?
A. I haven't seen him in a long time.
I said, well, except when I waste my time in depositions.
Q. Have you spoken to Dr. Ando since that time?
A. No.
Q. Have you spoken to anyone else involved in the case since that time?
A. No.
Q. What about before that?
A. No.
Q. Nobody other than Ando?
A. No.

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Q. Did you exchange any documents or e-mails with Dr. Ando?
A. No.
Q. What about anybody else?
A. Some years ago, when the wave of Celebrex cases were starting, Dick O'Malley of Sidley Austin asked me to collect all my documents, all my slides, all information of any sort, and they were then produced and scrutinized, and that was some years ago. My files were cleared and -- so.
Q. Do you know if those documents have been produced to the Plaintiffs in this case?
A. I have no idea.
Q. I want to talk a little bit about your employment history. I don't want to get too deep into it, but just for the record I'd like to talk a little bit about that.
Tell me about your education.
A. I have a bachelor's degree in pharmacy.
I have a master's degree in pharmacology.
I have a Ph.D. in pharmacology.
And I had three years of post

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doctoral training.
Q. Where are those degrees from, what universities?
A. My bachelor's and pharmacy degree were from --
You know, I never had a cold like this. Do you think it's New York?
Before I -- so, I've never been five miles west of the Hudson River until I went to St. Louis.
My bachelor's and master's degree was in Philadelphia, Philadelphia College of Pharmacy.
My Ph.D. was the University of Maryland Medical School.
And I then went to St. Louis to be a post doctoral fellow at Washington University Medical School. I've been in St. Louis since 1964.
Q. What was your first, after your education, what was your first job?
A. Assistant professor of pharmacology at Washington University Medical School.
Q. How long did you hold that position?

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A. In -- that was '67.
In 1976 I became chairman of the department, and I was chairman of the department until 1989.
Q. What happened in 1989?
A. I became chief scientist of Monsanto Corporation.
Q. Why did you make that change from academia to Monsanto?
A. In academia I had made many discoveries that had profound therapeutic implications, and in academia you don't finish and develop drugs.
So, in Washington University I discovered a new endocrine system, and then when I discovered the target COX-2, I saw its potential and knew I ought to see one project all the way through to the end; so, I went as chief scientist to Monsanto.
You know, we may have trouble getting through this day. We'll limp along, but you may have to visit me in St. Louis.
Q. I have a close friend who lives in St. Louis --
A. Who is that?

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Q. I don't have any problems. I don't think you know him, Doctor.
So, you discovered, you were talking about discovering, I guess, the COX-2 inhibitor?
A. No. First it was the target.
Q. Explain that to me. Tell me about the target.
A. The enzyme COX is an enzyme that converts a fat, arachadonic acid into prostaglandins. There's a whole family of prostaglandins, some that are beneficial, some that are related to inflammation.
The whole history of the treatment of pain and arthritis is built on drugs, first, that came from the bark of trees, salicylic acid, and then aspirin.
And they were used for 75 years before it was discovered that all aspirin-like drugs, all non-steroid anti-inflammatories, block the production of prostaglandin, and it's the prostaglandin in the joint, it's the prostaglandin that causes the pain. The discovery won the Nobel Prize for John Vane.

What he discovered was the doses that cause relief of the pain were the same doses that caused the side effects, especially the bleeding ulcers, perforation, and the thrombosis.

It was subsequently found that the mucous lining the stomach and in the gut, which protects the stomach from acid and the things that broke down protein, is produced because of prostaglandin.

So, the aspirin-like drugs destroyed the ability to make mucous, and that predisposes it to aspirin.

So, with that discovery, it was believed that it was a mechanism-based side effect. You block COX.

Over the next ten or more years I found the existence, that there were two forms of COX, two different genes, and from that I surmised that one was tied to the inflammation, and a different one was to the side effect.

With that knowledge, we predicted you could have a magic bullet that would hit the inflammation without causing the

mechanism-based side effects. And that's why I left Washington U to discover the agents that could make that possible.

Q. Well, let's go back to your employment history.

In 1989 you went to Monsanto. What was your position there?

A. Chief scientist.

Q. How high up in the organization were you?

A. I reported directly to the CEO.

Q. So, that's pretty high?

A. Pretty high.

Q. And did that company, did Monsanto later merge with Searle?

A. Monsanto is a conglomerate agricultural company, chemical company, nutrition company, and it had a core of science that had the skills in molecular biology, cell biology, chemistry, some of the things that support.

There was an acquisition of a small pharmaceutical company in Belgium.

Later, there was the acquisition of Searle, which also brought Nutrasweet.

The chief scientist had responsibilities to look at all the science, but to run this core of sciences that were necessary for all of the companies.

In 1993 I was also asked not only to be chief scientist, to become the head of R&D of the Searle arm of Monsanto, which was the pharmaceutical arm.

Q. How long did you keep that position?

A. From 1993 to 2000, when then there was a merger of Pharmacia and Monsanto, and then I became chief scientist and head of R&D of the Pharmacia R&D arm, which was the conglomerate.

Q. Do you remember who you reported to while you were the head of R&D for Searle?

A. The CEO of Monsanto was a Richard DeSchutter, until about 1999, and then the CEO was a Bob Shapiro of Monsanto; so, he was the final tip of the pyramid.

In Searle, there was a CEO, Shelly Gilgor.

But ultimately in the Shapiro model, it was kind of a co-run Searle between

the head of the business and the head of R&D. In Pharmacia it all reported to Fred Hassan.

Q. So, when you were at Searle you basically shared responsibility for running the company with Mr. DeSchutter or Mr. Shapiro?

A. No. Shapiro was the final, as head of the corporation, was the final leader of the corporation.

Q. But you had said that there was some type of shared responsibility for leading the company?

A. But we still reported to Shapiro.

Q. Okay.

MR. HOFF: I think the confusion is that the share was with Shelly --

THE WITNESS: Gilgor.

MR. HOFF: That's who you shared the responsibility with?

THE WITNESS: No. No. Gilgor was gone, and then I shared it with DeSchutter.

MR. HOFF: All right.

Q. So, you and Mr. DeSchutter shared responsibility for running the Searle arm of

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the company?
A. Reporting to Shapiro.
Q. Okay. You said that when it, when Pharmacia merged with Searle, your superior became Fred Hassan, he was the CEO at the time?
A. Right.
Q. Did you know Mr. Hassan before the merger?
A. No. Well, only in the pre merger discussions.
Q. Do you remember when that, when those discussions began, generally?
A. Somewhere around 2000.
Q. So, that would be the first time you met Mr. Hassan?
A. That's right.
Q. What kind of working relationship did you have with Mr. Hassan?
A. I had good relationships with all of the CEOs.
Q. Did you work in the same building?
A. The pharmaceutical arm of Pharmacia was located in St. Louis, San Francisco, Kalamazoo, Nerviano, Italy.

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So, the research sites were widely distributed. The corporate offices were in Peapack, New Jersey.
I would spend some time in Peapack, the majority of the time at their R&D sites.
Q. Mr. Hassan had an office in Peapack, as well?
A. Only in Peapack.
Q. How often did you speak to Mr. Hassan?
A. We had a regular monthly, ah, we would have a prolonged lunch.
And then, once a month, yes, that was the major, that was the major meeting I had with him.
Q. That was once a month?
A. Yes. Then they would have, um, some kind of executive management committee that would review all things, business and sales, and so on, and that would happen once a month also.
Q. So, there were -- and at least twice a month you had a fairly long meeting with Mr. Hassan?
A. The first one was one-on-one, the

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other would be a meeting like this.
Q. At the second type of meeting, a meeting like this, were there a lot of people in the room, was Carey Cox there?
A. Yes.
Q. And what was Mr. Cox's role in the company?
A. Ms. Cox.
Q. Ms. Cox, sorry.
A. I'll tell her about this if I ever see her.
Q. You can do that.
A. I see.
She was the head of the U.S. business, the sales force, and the business strategy.
Q. Did you meet with Ms. Cox, other than this monthly meeting that you had with Mr. Hassan?
A. No.
Q. Who else would be at these meetings, besides Ms. Cox and Mr. Hassan?
A. There would be international sales, there would be law -- the chief counsel --
THE REPORTER: I did not hear you.

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Law?
A. That's like people who make a living worried about litigations.
Contracts.
Head of manufacturing. You know. All the people who would be involved in the head of HR.
Q. How many, roughly, people?
A. Eight or 10. It was like an OTC business. There was an information technology officer.
Q. What types of things would you discuss at these meetings?
A. I would mostly listen. By and large, it's the review of business strategy, sales, contract negotiations in licensing, the blocking and tackling of a big corporation.
Q. During these meetings, what would they rely on you to provide, what type of information would you provide to the group?
A. If there was, for example, a review of an in license product, I would give a technical review.
Q. When you say "technical review,"

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tell me what that means.
A. You have a disease, you have certain symptoms.
You have a potential therapeutic agent.
And the questions are its efficacy.
Is it orally biovailable?
Is it long-lasting?
What are its cost of goods?
What is the level of side effects?
What is the ratio of benefit/risk?
What is the state of the competition?
What is the regulatory hurdle?
So, for example, is it a trial that will take six months with 200 patients that are on, or is it going to take five years and 12,000 patients?
So, I analyze the pros and cons of the benefit/risk ratio, the trial, the expectations, the competitive position.
Q. The answer you just gave me seemed to be you were talking prospectively.
A. You asked me what I would talk about. That's what I would talk about when

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there was a product.
Q. Right. And I appreciate your answer.
But your answer was prospective. I mean, you were telling them about something that was going to happen in the future, should we invest in that drug. Is that a fair characterization of what you just told me?
A. That's correct.
Q. Did you ever, if you had a drug that was developed and approved, did they also ask you questions about the science of that drug, if there was a question about it?
A. Not at those meetings.
Q. Now, you also mentioned trials, you would discuss trials in the meetings.
Were you only discussing trials that Pharmacia was going to run, or did you sometimes discuss trials that had already been run?
A. As you just established, it was prospective projections. Often, when you in license, a drug has been through Phase I safety, Phase II small trial, you're usually

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asking the question, are you going to do the big multiple site, multiple nation trial.
And you would discuss what is the design to get the effect that you want.
Q. When did these meetings begin?
Pharmacia and Searle merged in 2000 -- do you remember if they started immediately?
A. This was a custom already present in Pharmacia. So, we just snapped right into the system.
Q. So, as soon as the merger started, or excuse me, as soon as the merger closed, you would have been present at the first such meeting?
A. Correct.
Q. And Mr. Hassan would have been there?
A. Correct.
Q. And Ms. Cox would have been there?
A. Correct.
Q. Did you always attend these meetings?
A. Always? Always is perfection.
I might have missed one or two, if

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I was engaged in something.
Q. They were important meetings?
(Phone - handheld - chiming)
A. My phone doesn't think so.
Q. Would you call them a command performance?
A. I think it was useful to have a discussion with multiple viewpoints. It was a useful way to run a company.
Q. Are you currently doing any work for Pharmacia?
A. No. There is no Pharmacia.
Q. Are you currently doing any work for Pfizer?
A. Only sitting here, and that's because I was subpoenaed.
Q. Pfizer is not paying you to be here; are they?
A. I do get a consultation fee.
Q. Are you getting a consultation fee for anything other than this deposition?
A. From Pfizer?
Q. Yes.
A. No.
Q. What consultation fee are you

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getting for being here at this deposition?
A. Do I answer that? It's not enough.
MR. HOFF: I think we have to talk about that.
Q. Well, is it more than $100?
THE WITNESS: Is that their business? It doesn't seem like it --
MR. HOFF: I'd like to talk about that. When we take a break, we'll come back to that issue.
MR. OLIVER: Do you have an objection?
MR. HOFF: I want to find out a little bit more about that.
MR. OLIVER: Well, if you've got an objection, raise the objection. I want him to answer the question now. If you want to take a break and talk about it, we'll --
MR. HOFF: Why don't we do that, if you want. Let's take a break then.
MR. OLIVER: Well, actually there's a question pending.
DI MR. HOFF: All right. I'll object to the question, and I direct you not to

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answer it.
MR. OLIVER: And what's the ground for your objection?
MR. HOFF: Privileged.
Let's go off the record.
MR. OLIVER: All right.
THE VIDEOGRAPHER: Off the video record at 9:44.
(Recess)
MR. OLIVER: Back on the record.
THE VIDEOGRAPHER: Stand by. Back on the video record at 9:47.
Q. Doctor, I think the last question I asked you before the break was what consultation fee are you getting for being here at this time.
A. In all the previous depositions I've given, my consultation fee was $500 an hour.
Q. Are you getting that same consultation fee for this deposition?
A. Um, I don't know if there's any restrictions about that. I had assumed that. I don't know if there's something special about the reason that it is or isn't the case

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here.
Q. But are you, are you getting that fee?
A. I don't know that answer yet. I had expected one, but if there's a problem, I'll hear about it.
Q. Before I asked you the question -- excuse me, after I had asked you the question, you went and talked to your attorney about this matter. Is that correct?
A. (Indicating).
Q. What did you discuss with him?
DI MR. HOFF: I'll direct him not to answer that question.
Q. Did he instruct you on how to answer a question?
A. I'll pay attention when he tells me not to answer a question.
Q. If you are getting paid a consultation fee in this particular case, who is paying it?
A. Ultimately, Pfizer.
Q. You say "ultimately." Is there some --
A. I send the bill to someone who

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passes it to Pfizer.
Q. You send the bill to somebody at Pfizer?
A. No. The clearinghouse person was that -- Dick O'Malley, Sidley Austin.
Q. You said it was $500 an hour?
A. Um-hum.
Q. Have you talked to anybody about that fee before --
A. This session?
Q. -- this session?
A. No.
Q. Why did you assume you would get it?
A. Because I got it in all the other depositions.
Q. Were you employed by the company at the time of the other depositions?
A. No.
Q. Nobody has talked to you about it before this deposition?
A. No.
Q. You don't know if you're going to get it for this deposition?
A. No.

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Q. Are you going to ask for it?
A. Yes. But I wouldn't screw up the case over a small issue like that. I'm here because I believe in COX-2 and Celebrex.
Q. Well, that merges nicely into what I want to talk about now, which is COX-2 and Celebrex.
What is Celebrex?
A. Celebrex is a selective COX-2 inhibitor that, at fully efficacious doses, relieves the signs and symptoms of arthritis by inhibiting COX-2 and not COX-1.
Q. You described your role in this, in the discovery of Celebrex.
Can you, it seemed to me you were focusing on the discoveries that happened while you were at the university. Can you tell me about your work at Monsanto and then Searle, on Celebrex?
A. Your statement wasn't correct.
Q. I'm sorry, what was incorrect?
A. The target was discovered in academia. All the work for the discovery, the optimization and the testing of the drug, was done in Monsanto/Searle.

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Q. So, you began that work in 1989 when you joined Monsanto?
A. The drug part.
Q. When you started at Monsanto, did you have a timeline of how long this would take to develop this into a drug?
A. No. You can't know that answer.
Don't forget, this is a brand new hypothesis that's a uniquely different enzyme. In my experience, it's often taken 10 or 20 years to go from a target to a drug.
Q. How long did it take with Celebrex?
A. It went on to the market in 1999.
Q. Why was a company like Monsanto interested in this particular enzyme?
A. I think there might be 40 or 50 million arthritis patients in the United States.
The insets that I told about, there was a study from Stanford by a Dr. Singh, the ARAMIS study.
It works out that NSAIDs are the biggest single cause of drug-induced hospitalizations and caused 16,500 deaths a year in over 100,000 severe hospitalizations

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from the GI side effects.
So, it was an important drug, and a lot of arthritic patients couldn't take it. So, if we could find a selective agent, it would have had a very significant safety advantage over existing NSAIDs.
Q. It would have also been hugely profitable, I assume?
A. If it met expectations, it would have been an important drug.
Q. What expectations would it have had to meet?
A. As I explained to you before, maintaining the treatment of the signs and symptoms of arthritis, but with less side effects.
Q. Less side effects in general, or less GI side effects?
A. Both the GI and bleeding side effects, because COX-1 also inhibits a cycloxygenase in platelets.
There it doesn't make prostaglandin, it makes thromboxin, and that's what causes platelets to clump.
So, the difference between an

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aspirin, and which hits COX-1 and COX-2, and a COX-2 inhibitor is COX-2 inhibitor won't inhibit platelet aggregation and, therefore, have a bleeding tendency.
Q. Is it fair to say that given your answers, is it fair to say that Celebrex was meant to compete with or take over part of the market that NSAIDs operated in or covered?
A. What I think is fair to say was, Celebrex had a chance to be a superior therapeutic agent, with an improved efficacy to risk ratio.
Q. Have you ever heard Celebrex called super aspirin?
A. Yes.
Q. Do you know who coined that phrase?
A. The guy who wrote the New Yorker article.
Q. What New Yorker article?
A. There's a New Yorker article called "Superaspirin."
Q. Was the superaspirin article before the approval of Celebrex? The FDA approval of Celebrex.

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A. You know, I'm not sure. I'm not sure.
Q. When did the FDA approval Celebrex?
A. December 31st, 1998. Kind of interfered with my New Years Eve.
Q. You remember that date?
A. It screwed up my New Years Eve.
Q. Why?
A. You see, the FDA has kind of a mandated set of targets that they want to approve; so, they were finally, the advisory committee was earlier for the NDA; and so, they were, that was part of their last day of the year activities.
Q. What company were you with when they approved Celebrex?
A. Searle. I was with Searle in '98, which is Monsanto.
Q. Were any other companies participating with Searle in the development and marketing of Celebrex?
A. There was a joint development and marketing agreement with Pfizer which started in about, about a year before the approval.
Q. What did the approval of Celebrex

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mean for Searle as a company?
A. When you ask me what Celebrex meant, I recited the first line of the FDA NDA approval.
And the fact that the FDA was satisfied that Celebrex improves the signs and symptoms of arthritis at doses that inhibit COX-2 and COX-1. That really positioned the drug to be understandable by any practitioner that it had a therapeutically improved benefit/risk ratio.
Q. But for the company Searle, as a business, what did the approval of Celebrex mean?
A. It meant that it could really be a significant player in arthritis.
Q. Did that actually happen?
A. Yes.
Q. Was Celebrex a successful launch?
A. Yes.
Q. How successful?
A. I think, at its time, it was the most successful launch of all times.
Q. Do you know if it still remains the most successful launch of all time?

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A. I don't pay much attention.
Um, some of these antibodies for oncology must do pretty well. If you talk about the slope, I don't know.
Q. Was Celebrex Searle's most important product at the time?
A. Yes.
Q. Was it the largest profit driver after approval?
A. It was -- as a single product, it was.
Q. "As a single product." Explain that.
A. A drug company has a lot of products. The aggregate sales of other things would have been as great as Celebrex.
Q. But if you broke it down product by product, Celebrex was the biggest?
A. Um-hum.
Q. By how much?
A. Yes. I don't remember numbers.
Q. Can you give me a guess?
A. No.
Q. What, when the FDA originally approved Celebrex, what did the label say? I

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understand you're not going to know exactly.
A. I recited it to you twice.
Q. Well, you didn't recite the whole label to me.
A. That's the most important part.
Q. Well, let me finish my question.
What did the label say about GI side effects?
A. I don't remember the language.
Q. Can you tell me generally what it said about GI side effects?
A. I don't remember the language.
Q. Did it say that Celebrex is better than NSAIDs?
A. Perhaps you could give me the label, so I could read it to you. I don't remember.
MR. OLIVER: I guess this will be Exhibit 232.
(Needleman Exhibit 232, documents Bates Nos. 1767 to 68, marked for identification as of this date.)
Q. Do you recognize this document?
A. I could tell you it's not the label.

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MR. HOFF: Do you have another copy?
MR. OLIVER: Yes.
Q. Doctor, when he gives you the document, take a minute to look it over and familiarize yourself with it. Take as much time as you need.
A. May I take this?
MR. HOFF: Is that previously marked?
THE WITNESS: It says Exhibit 2, but then it says Exhibit 232, also.
MR. OLIVER: I don't think so, Doctor.
MR. HOFF: Okay. So, we're going to ignore this Plaintiff's Exhibit 2 label?
MR. OLIVER: Yes. I'm sorry.
I explained this to the court reporter earlier.
That's just linked to me.
MR. HOFF: I just wanted to be clear.
MR. OLIVER: Those numbers are irrelevant, as long as he puts the new

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stickers on there.
MR. HOFF: Okay. Go ahead.
Q. Let me know when you've had a chance to just briefly read over that, Doctor.
(Pause.)
A. Thanks, I've read it now.
Q. What does the document appear to be to you?
A. This seems to be someone who took minutes of the proceedings of the FDA sessions after the advisory committee in the review for the preparat' agreements about the final label.
Q. You were at that meeting; correct?
A. Yes.
Q. Would you look in the second paragraph with me. It says, "Needleman" -- that's you; correct?
A. We've wasted a lot of time if it's not.
Q. Okay.
"Needleman stressed that data are still being suppressed in the label despite the size of the database, and that this did

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not provide a level playing field."
Can you explain that statement to me?
A. As I recall, the initial label proposed by the FDA wanted to call Celebrex an NSAID, in spite of the advisory committee.
DeLap said to me, you don't know the mechanism of action.
I then listed 10 points that established the mechanism of action.
And from that discussion was the agreement it inhibits COX-2 at an efficacious dose, but not COX-1. That's a mechanism of action statement.
The size of the trial, the last NSAID that was approved before it, a drug like Relafin at 1400 patients.
The Celebrex trial had 13,400 patients, and 5,000 endoscopies, the largest trial of its kind. And so, um, the discussion was to reflect that.
Q. You wanted Celebrex in the final label to be separate from NSAIDs?
A. Correct.
Q. Did you want the label to also say

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that it was superior from a GI standpoint?
A. This note refreshes some part of the label, which I wished you could show.
But the FDA finally permitted a bar graph of endoscopy, and it showed that the doses of Celebrex, there was no endoscopic signal, it was baseline, but conventional NSAIDs caused an incidence of something like 20 percent of endoscopic lesions.
That graph, indeed, showed the differentiation from NSAIDs. And as this document said, the FDA took out the comments that said "like NSAIDs, Celebrex X." So, that was the discussion.
Q. Will you look at the -- there are some bullet point there; do you see those?
A. Yes.
Q. I guess, number 5. The last sentence under bullet number 5 says, "The NSAID comparison table" --
A. Wait. Number 5 starts with "Clinical studies"? That's 4.
And then it starts with the discussion of serious side effects.
Q. That's correct. Starting with

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discussion. The last sentence of that paragraph says, "The NSAID comparison table would be eliminated. See discussion of GI warning below."

Do you have a recollection of what NSAID comparison table they were talking about?

A. My recollection was they already agreed to the bar graph; so, you don't also need a table.

Q. Remind me. What did the bar graph compare again?

A. Endoscopy of the doses of Celebrex versus other conventional NSAIDs.

Q. If you look at the seventh bullet point with me.

This is the language that the FDA ultimately agreed to put in the label; isn't that correct?

A. My willingness to say Yes would be a lot better with the label in my hand. This is minutes of the label.

Q. Well, at least that's what this document indicates that language is.

A. It doesn't tell you the final label

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at all. There were a number of negotiations.

Q. It says, "FDA ultimately arrived with us at wording like this to be inserted underneath the standard warning."

A. I would have liked to have seen the label. I understand the context.

Q. So, you agree at least that it would be wording that is very similar to this that ended up in the final label?

MR. HOFF: Objection to form.

A. Let me play back the way I read this.

Because it's important for this discussion.

NSAIDs have an event rate of 1 to 2 percent of GI effects. Celebrex in this trial with 5,000 patients had an event rate of 0.06 percent.

If the label reflected that, that shows the differentiation projected from the 5,000 patients.

Q. Okay. If you look with me at the last sentence in that paragraph, it says "prospective long-term studies require to compare the incidence of seriously clinically

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GI adverse events in patients taking Celebrex versus comparator NSAIDs have not been performed."

A. Correct.

Q. Do you know if that language ultimately ended up in the label, or something like that?

A. I don't remember.

Q. If you turn the page, the same paragraph, about the middle of that paragraph beginning with "FDA still strongly feels"; do you see that?

A. Yes. Let me read that sentence.

Yes.

Q. I'm going to read that to you.

"FDA still strongly feels that direct comparison to NSAIDs data obtained the same way as Celebrex data would constitute a claim of superiority to NSAID and they will not let us have such a direct comparison until the CLASS studies are completed successfully."

Does that accurately reflect that FDA did not allow a comparison of Celebrex and NSAIDs in the final label?

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A. I think that's accurate. I think that's an accurate description of the need for CLASS studies.

Q. That class study, tell me what that is.

A. It's, um, based on an experience going back to an earlier anti-arthritis drug developed by Searle, which was a combination of diclofenac and a prostaglandin known as misoprostol.

As I told you, there was a mechanism-based side effect of causing ulcers when you have COX-1 inhibition.

Until you had a selective inhibitor like COX-2, you try to overcome the damage by adding prostaglandin back with a tube, with a tablet.

That led to a trial known as MUCOSA, and MUCOSA was a long-term trial of GI events comparing diclofenac to arthrotec, which is a combination of diclofenac plus misoprostol. So, that became a, that became the comparative standard on which the CLASS trial was designed.

Q. You gave me the background of

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CLASS, but I'm still not sure I got what CLASS is.
A. It's designed to do a comparative trial to go beyond what was in the NDA submission looking for more serious GI events than the endoscopic changes.
That's part of it.
But you had to go on to actually bleeds, ulcers, perforations, obstruction. Longer study. Bigger doses.
A more comprehensive focused kind of Phase IV trial to allow the superiority claim.
Q. So, the FDA had the MUCOSA data when they approved the original label for Celebrex?
A. The MUCOSA data preceded it by some years.
Q. But that was part of FDA's analysis of the entire issue in the labeling for Celebrex?
A. No. I never heard mention of MUCOSA at all in the negotiations about the NDA approval of Celebrex.
Q. Well, I'm sorry, maybe I'm using

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the wrong, maybe I'm getting MUCOSA confused with another study.
You were talking about a study that had proceeded CLASS. Was that MUCOSA?
A. Different drug. Arthrotec --
Q. Okay.
A. -- combination --
Q. Okay.
A. -- of misoprostol prostaglandin with diclofenac.
Q. When Celebrex was approved, FDA has the data from the Celebrex trials that were submitted with the NDA?
A. Correct.
Q. They say you can't make a claim of superiority over NSAIDs; correct?
A. That's correct -- not entirely, though. Understand, they published in the NDA the bar graph of the endoscopic data.
They also published that the incidence of GI side effects was .06 versus 1.2. They didn't want bigger claims until you did the long-term study just focused on that.
Q. And CLASS was that long-term study?

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A. That was our projected. CLASS is an acronym for Celebrex long-term kind of study. So, we always intended to do a long-term study.
Q. Who is "we"?
A. Searle.
Q. Was Pfizer involved in that at the time?
A. We were largely responsible for the design. It was Searle that did the MUCOSA trial.
Q. What role did you play in designing the CLASS trial?
A. I certainly would have heard the design, reviewed the assumptions.
It would have been reviewed with my executive committee, which would have a head of clinical and regulatory and other people.
Q. Sitting here today, can you recall the primary end-point for CLASS?
A. I think the primary end-point was perforation of gastric obstruction bleeds.
There was a series of primary and secondary, but -- I think also in the design was attention to bleeding markers such as

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hemoglobin, hemolysis, hematocrit.
They also embedded in such a trial -- it became very important later -- is, since you're at an exaggerated dose at a long period of trial, they required all systems safety, including liver, kidney, heart.
So, somewhere in the primary and secondary, that was part of the agreed design.
Q. Do you recall whether aspirin users were allowed to participate in the study?
A. Interestingly, that's a decision that was up to the company.
And our design allowed all comers, which would include people who were on aspirin, but if they were on NSAIDs, they had to withdraw, but they could have free use of aspirin.
Q. Was that a significant decision?
A. Um, by hindsight it was an enormous decision.
Q. If you can recall, at the time, what was the thinking for allowing aspirin patients into the study?
A. In the MUCOSA trial, there were

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only about 10 percent of the patients who were on aspirin.
Projecting that, which has the potential for a confounding effect, anticipating the same low population of aspirin patients was the design. That was, that was the prospective design.
By hindsight, that was a wrong assumption.
Q. Why was it a wrong assumption?
A. Because during the ensuing years cardiovascular disease exploded, the use of aspirin got lots of attention. There were very many more aspirin users who also implied cardiovascular risk. So, there's very many more.
Merck, for example, excluded all aspirin patients in the Vioxx trial.
Q. But Searle decided to include aspirin users at the beginning of the CLASS trial, because at that time it seemed like a more real-world, realistic assumption?
A. It was based on an incidence rate.
You designed trials based on your relevant therapeutic population.

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You understand from what I said earlier that aspirin is both a COX-1 and COX-2 inhibitor.
Q. Correct.
A. You do trials to understand your drug. If you would have known you had a very high level, the design isn't appropriate.
Q. So, Searle decides to allow aspirin -- you tell me if this is a correct statement -- Searle decides to use aspirin, allow aspirin patients into the class study, because, at the time, there were a lot of people in the relevant population who would be treated with Celebrex, who would also be on aspirin?
A. The design was --
MR. HOFF: Objection to form.
A. The design, as I said, was based on the experience of the MUCOSA trial.
When you design trials, there have to be inclusion, exclusion.
So, for example, if a patient has compromised renal function, if a patient has compromised liver function, they would be excluded in the design.

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So, that's just one of the parameters.
Q. Who participated --
A. If they had glucocortacoids, if there are -- remember, we also opened up the trial to all arthritics, both osteo and rheumatoid.
If we really wanted to fine-tune and bias it, we would have just done osteo. Rheumatoid arthritis have lots of other symptomatology and side effects.
Q. At Searle who helped, other than -- I understand your role -- who else helped you design the CLASS study at the higher level of the company?
MR. HOFF: Objection to form.
A. It's the responsibility of R&D to design the trial. Other people in the corporation aren't particularly influential.
The influential group is the key opinion leaders in clinical or academic practice.
Therefore, when you design a trial, you will often assemble a panel of people who are experienced practitioners in the disease,

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in the conduct of clinical trials, and understanding the therapeutic agents. Those are the people, not the upper management; so, it's an R&D decision, influenced by key opinion leaders.
It's also influenced by discussions with the FDA itself.
Q. Did Mr. DeSchutter have any role in designing CLASS?
A. No.
Q. Did he have to approve the CLASS study?
A. No.
Q. Do you remember briefing Mr. DeSchutter on the CLASS study, before it was started?
A. I don't remember.
Q. He was the CEO at the time?
A. This was my decision. It wasn't a matter of the CEO or --
Q. You were the final decision-maker for CLASS?
A. (Indicating).
Q. Everything had to pass through you?
MR. HOFF: Objection to form.

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A. That's correct.
MR. OLIVER: What's the objection? What's wrong with that.
MR. HOFF: Everything. What does that mean?
Q. All significant decisions that related to the CLASS trial had to receive your review and approval; is that correct?
A. If I was against it, it would have had trouble going forward.
The nature of the decision is not a regal decision all or none, it's a constant analysis of the input of the science, the clinicians, the issues, it's a balanced study that you reach a reasonable consensus. And it also involves the FDA.
The FDA, if they weren't satisfied, could greatly influence the trial.
Q. Do you recall whether the FDA greatly influenced CLASS?
A. There were pre, pre-trial meetings with the FDA.
Q. Do you recall any particular way in which the FDA had a role in how CLASS was structured?

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A. I pause because ultimately the design is their understanding of our approach, which they would have given feedback about.
The guidance is a discussion of our design and theirs. I don't recall if they had some specifics. The reason -- in the end, the trial by Merck was not the same trial as this trial by Searle. So, there's differential feedback.
But the FDA did not object to our design, and there were discussions, more than one discussion, about what the trial would be.
Q. Doctor, I'd like to show you what is going to be Exhibit 233.
(Needleman Exhibit 233, documents Bates Nos. 7112 to 7327, marked for identification as of this date.)
MR. OLIVER: John, this is Exhibit 66. The final CLASS report doesn't have the appendices in it. That's the only thing that's missing from it. It's just a matter of size.
MR. HOFF: 233 doesn't have the

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appendices?
MR. OLIVER: Yes. Do you -- I mean, do you want to refer to it as 66, or 233?
MR. HOFF: Why don't you just say on the record that it's also been marked Exhibit -- just say what you just said, and then we'll -- when we go back to it later on, we'll -- if that works for you.
Q. Doctor, the court reporter is handing you what's previously been marked as Exhibit 66.
It's now being marked as 233. This version does not have the appendices that go with this exhibit; but otherwise, it is exactly the same as Exhibit 66.
Can you tell me what this is?
A. Not until I look at it.
Q. Take your time.
(Pause.)
A. So, this looks like the final report submitted to the FDA of the CLASS data by the lead clinician on it, Jim Lefkowith.
Q. What's the date on it? If you look

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at the first page, what's the date on the document?
A. The document date is May 25th, 2000.
Q. And this was post merger of Pharmacia and Searle?
A. I think that's correct.
Q. At that time do you recall who the head of the company was?
A. Fred Hassan.
Q. Where was Ms. Cox in that structure?
A. She always was just the person who ran the U.S. business.
Q. What about Mr. DeSchutter, was he still there?
A. Um, he left pretty quickly after the merger.
Q. Would you -- what role, if any, would you have played in preparing this report?
A. Preparing the report, um, I think no particular role.
Q. Would you have reviewed drafts of it?

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A. I don't think so.
Q. So, tell me how the process works.
You have these clinicians who are doing the CLASS study, they just show up at your door one day with this class report? Is that how it works?
A. No.
Q. How does it work?
A. It is, there are many reviews of the data and discussions of issues. The data, the data comes in waves.
Q. Take your time and get some water if you need it.
A. This day is not getting better. You know, I've never had this. Do you think it's you?
MR. OLIVER: I think it is. I think maybe I brought it up here for you, Doc.
THE WITNESS: Maybe it's being back close to New Jersey and New York.
MR. OLIVER: You don't think I put a hex on you; do you?
A. I'm not worried about you raising my very low blood pressure.

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Data comes in. There's more and more scrutiny of the data.
Do you understand the complexity of the data is millions and millions of data points, confirmations, you saw that's from 386 sites.
So, the scrubbing of data and the understanding of the data goes on over a certain period of time, both internally and with experts.
So, I would have been privy to those discussions, but not involved in scrutiny of the document; but understand the context of the document.
Q. Who would have reported the -- you said that --
I'm sorry. Strike that.
You said that there were summaries of the data and scrutiny of the data internally.
A. You said the word "summaries."
At various times I had data presentations --
Q. Fair enough. Who gave you the data presentations?

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A. It would have involved Jim Lefkowith, Steve Geis, Rich Spivey, the head of regulatory. By then, the head of clinical was Michael Friedman.
Some statisticians. Those kinds of people.
Q. How many of these types of presentations would you have had before the final report was issued?
A. I can't recall.
Q. Would you have had these types of discussions before the unblinding of the data?
A. No.
Q. Would you have had --
A. These types of discussions that lead to the submitted document; that's your question?
Q. Yes.
A. No.
Q. Would you have had Dr. Lefkowith or Dr. Geis tell you general information about the study before the unblinding?
A. The most important discussion before was this was an event-driven trial.

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Q. I'm sorry, Doctor, I told you I wouldn't interrupt you. Before what?
A. You said did I have discussions before the submission.
The target event rate reached a point where it wasn't hitting, it wasn't progressing to the final number, and there was a considerable period of time.
So, the discussion was should the trial be stopped with the number of events we had.
Blinded data.
And those meetings, without breaking of the blind, led ultimately to the termination of the trial. It was not a specific time target, it was an event target.
Q. Was Mr. Hassan involved in any of those discussions?
A. No.
Q. What about Ms. Cox?
A. No.
Q. Why not?
A. They never would have been.
Ms. Cox was never involved in anything.

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Hassan did not in any way engage in the design in that kind of a discussion.
Q. What about after the unblinding, you mentioned some, you called them data presentations, to use your words. After the unblinding --
A. To me.
Q. Okay.
Well, do you remember when the unblinding was?
A. No.
Q. If I tell you that it was March 17th --
A. It wouldn't mean a thing to me.
Q. -- 2000?
If you'll look at the first page of this exhibit, where it says "study dates."
A. Yes.
Q. It says 17 March, 2000.
A. Yes.
Q. Does that refresh your memory?
A. No. Because a clinical trial involves a certain target number of patients. I think there might have been 4,000 in the two-arm trial.

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The enrollment time before you hit the full number is spread out over a number of months.
The termination time is off of the last patient. There's then a period where the data is analyzed. It's not analyzed before.
I would assume that the data was not analyzed by March 17th; that's the last time the patient got a treatment.
So, analysis usually starts after the last patient.
Q. But I'm asking about unblinding.
A. Well, that's the beginning of the data analysis.
It wouldn't have been, in my opinion, before March 17th, but afterwards.
Q. Okay.
Let's back up.
Between unblinding, whatever date that happened to be, between unblinding and the date of this report, May 25th, 2000, you said there were data presentations about, ultimately, what would go into this report.
A. Correct.

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Q. Who was present, besides yourself, at those data presentations?
A. I listed that already. Maybe your court reporter should say it again.
Q. Can you go ahead and answer the question?
A. The clinical people would have been Lefkowith, Geis, probably Michael Friedman, who was the head of clinical.
Regulatory, Rich Spivey.
Some statisticians.
It probably also involved the rest of my senior staff. So, the head of pre-clinical would have been Larry Hanson.
The head of discovery, John McKern. Whoever my senior staff was.
Q. Mr. Hassan would not have been there?
A. Absolutely not.
Q. What about Ms. Cox?
A. Absolutely not.
Q. How did they find out about what was happening with the CLASS trial, if they weren't at these meetings?
A. I would say, eventually, when we

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understood the data, it's most likely that Hassan would know from my monthly meeting with him.
Q. So, at the monthly meeting you would give him an update on whatever it was you had learned about CLASS in the most recent data presentation?
A. Sometime or other I would review whatever was significant in our portfolio of products.
Q. Do you recall any particular discussion you had with Mr. Hassan on this issue?
A. No.
Q. You said earlier that this report went to the FDA, this final report.
A. That's what the report looks like. It says "final report." I assume it went to the FDA.
Q. Who else would it have gone to, other than the, you, and the FDA, within the company, who would have gotten a copy of this?
A. Um, what I'm not sure of is, um, what the Pfizer people would have gotten.

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So, it's -- it seems to me that it could have gone to the clinical people in Pfizer.

And I have to think, in my earlier answer, if any of the Pfizer people sat in on the meetings, um, I actually don't think so.

So, these meetings would have been conducted in Skokie. Hassan, Cox, I don't think were ever in Skokie. I don't think the Pfizer people came to Skokie.

But they would have been appraised of this, and there would have been discussions with the Pfizer R&D people, not with the business people or the marketing people.

Q. Who would have apprised Mr. Hassan and Ms. Cox of this information?

A. For me I know of no connection with Ms. Cox, and I would have been the one that discussed it with Hassan.

Q. Do you remember discussing it with Mr. Hassan?

A. Not the specific, but I discussed the entire portfolio with Hassan, when I would meet with him.

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Q. Do you know if he got a copy of this report?

A. It seems illogical that he would have gotten a copy of this report.

Q. Well, that wasn't my question.

Do you know if he got a copy of it?

A. Neither -- I don't know, nor could I see any reason to send it to him.

Q. What about Ms. Cox?

A. The same answer.

Q. Doctor, if you will go to the third page of this exhibit with me. Midway down the page there's a chart that says "synopsis"; do you see that?

A. No. My third page has objectives.

Do you mean the fourth page?

MR. HOFF: Here.

A. Oh. Up here. Got it.

Q. Yes, sir. Do you see that synopsis?

A. Yes.

Q. Okay. If you go down to the middle of the page, where it says "objectives," it says "primary, to compare the incidence of clinically significant upper gastrointestinal

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events (CSUGIEs) associated with celecoxib 400 milligrams BID, to that associated with Ibuprofen 800 milligrams TID or diclofenac, 75 milligrams BID in patients with osteo-arthritis or rheumatoid arthritis."

Do you agree that that's the primary end-point of the CLASS study?

A. That's what it says.

Q. Can you explain that to me?

A. This is the trial that we discussed earlier, modeled on MUCOSA.

It's describing, um, a dose that's extremely high, four times the dose of the osteo-arthritis, and it has the two comparators, and it's looking at the parameters that would mark the gastrointestinal events, upper GI trend.

I agree that's, that's the primary.

Q. This primary end-point, is it fair to characterize this as ulcer complications?

A. I'm sorry?

Q. Is it fair to characterize the primary end-point as ulcer complications?

A. It's more than ulcers.

Q. I said "ulcer complications."

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A. Well, I don't know.

I mean, obstruction is not necessarily an ulcer complication. I think that's just part of the whole scenario of the GI events.

So, it's -- it's, ah, it's looking at perforation, that's ulcer. It's looking at obstruction. It's also looking at bleeds, and bleeds could well be more than upper GI, it could be the whole GI.

So, just a question of your terminology. But the generality is that would be an aggregate describing -- not quite accurate, but it would be the aggregate.

Q. Would it include symptomatic ulcers?

A. No, it wouldn't.

If symptomatic ulcers meant --

Well, maybe tell me what you mean by symptomatic ulcers.

Q. Well, Doctor, this is your study. You tell me what symptomatic ulcers means in the context of CLASS.

A. You raised the question. There's a lot of parameters in symptomatic ulcers --

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dyspepsia, pain, abdominal cramps, and endoscopy. So.
Q. A non-bleeding ulcer identified by endoscopy would not be included in the primary end-point of the CLASS study; is that correct?
A. But there are other symptoms besides bleed or not, as I told you.
It's heartburn, gas, and so on.
So, that would be the aggregate of symptomatic.
Q. If you'll look down with me on the same page, under "methodology," go about to the middle of the paragraph beginning with "treatment duration."
A. Yes.
Q. "Treatment duration lasted for at least 26 weeks with a maximum potential treatment period of 52 or 65 weeks."
Is that an accurate characterization of the treatment period?
A. That's an accurate regurgitation of what's written here.
The relevant thing, for me, is "at least 26 weeks." Remember, it's an event

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trial, not a time trial.
So, you set the minimum and then the question is: When do you accrue enough events?
Q. This document is the final report that went to the FDA and was circulated internally, and it defines "treatment period" in the way that I just read it to you. You would agree with that?
A. It says "at least 26 weeks"; so, it sets the baseline parameter and also sets the maximum, if you need it.
Q. But it doesn't say if you need it in the document; does it?
A. It says -- you read the statement -- "lasted for at least 26 weeks."
And then it says, "with a maximum." So, 26 weeks would have been enough, if you had the events.
Q. But that's not my question.
My question was, you added some words in there, "if you need it."
It doesn't say that.
MR. HOFF: Objection. Arguing with the witness.

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A. Treatment duration lasted for at least 26 weeks, with a maximum potential of 52 or 65 -- that's what it says. I agree with what it says, not what you say.
Q. Fair enough. You agree with what's on the paper. If you will turn with me to page 34 of the exhibit, please.
A. So, looking at the numbers on the top?
Q. Yes, sir. On top of the page. Page 34 of 24,295. And we're about a couple thousand pages short, I think, here.
A. Maybe tens of thousand of pages short.
Q. Perhaps. I'm trying to lighten the load. Have you made it to page 34?
A. Yes.
Q. If you look down at the bottom of the page, do you see where it says "treatment period"?
A. Yes.
Q. Can you read that first sentence for me.
A. Let me read the whole thing, so I see what the context is.

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Q. Take your time.
(Pause.)
A. Okay, please repeat your question.
Q. Can you read the first sentence under "treatment period" for me.
A. Yes, I can. "The treatment period was the period during which medication was taken." You wanted just the first paragraph?
Q. I'm sorry, the first two sentences.
A. "For each patient, this period was scheduled to last for 52 or 65 weeks, or until the trial officially concluded."
Q. Is it fair to say that this document defines the treatment period as 52 or 65 weeks?
A. You're ignoring the end of the sentence: "The trial could have been concluded when we accrued enough events."
I think the target events was 40, in the design. If we, whenever we would have accrued the number, or approached the number, that would have concluded the trial.
Q. Do you recall when you approached the number?
A. That was the discussion that led us

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to terminate the trial, and I think that had reached 38 at the time, some number like that.
Q. But it was longer than six months. You didn't conclude the trial at six months?
A. As I recall some part of this, you remember I told you the trial time is determined by a sliding rate of enrollment.
I actually think the -- and that was refreshed for me that the mean number of days at the end of the trial during treatment was something like around six or seven months, 180 or 200 days.
But it's a spread, because of the differential enrollment rate. Some go on longer, some less, because there's a differential in the enrollment rate.
I think, in the end, the average that the FDA took was nine months.
Q. Doctor, if you will turn back to page 3 with me, where we were originally.
Take a second to read the number of patients section at the bottom.
(Pause.)
A. I've read it.

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Q. Okay. I'm looking at the second sentence: "A total of 8,059 patients were enrolled, of whom 4,573 completed six months of treatment --
A. Yes.
Q. -- and 3,409 completed the study."
A. Yes.
Q. At least there you would agree with me that there's a clear distinction between six months of treatment and the study?
A. Yes.
Q. Turn with me to page 6.
You see the summaries of the CSUGIE incidence?
A. I do.
Q. Tables 1 and 2. You would agree that CSUGIE, CSUGIEs, was the primary end-point of the study?
A. Yes, I do.
Q. Okay. I would like to go over this, but before that, I want to get a firm grasp of, just generally, how the study was run, in terms of what drugs were involved and what you were comparing.
I don't want a whole lot, just, you

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know, what drugs are we talking about, Celebrex versus what?
A. Celebrex dosage, 400 milligrams BID, that's four times the osteo arthritis dose.
The commonly used dose of diclofenac, 75 milligrams BID.
The commonly used dose of Ibuprofen, 800 milligrams, BID.
Those are the prescribed initial doses. Actually those doses are used at higher levels of patients.
And it was a -- so, there was a comparison of those three drugs, divided into kind of a two-arm study -- Celebrex, versus one, Celebrex versus the other.
Q. Did you also compare Celebrex to both of them combined?
A. You mean, did a patient get both drugs?
Q. No. No. I'm sorry.
At the end of the study, did you compare Celebrex -- you said you compared Celebrex with Ibuprofen, you compared Celebrex with diclofenac.

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Did you also compare Celebrex to diclofenac and Ibuprofen together?
A. As I recall, in the NIH-agreed design, there was a sequence of analysis and criteria for going through the data, the first level of which is Celebrex versus the combined.
Only if positive, you can go to the further analysis of Celebrex versus each individual.
Q. What's the NIH?
A. I'm sorry. Freud lives.
It's the FDA.
The NIH is a whole world that describes science, to the other half of my --
Q. You didn't mean the NIH, you meant the FDA?
A. I meant the FDA.
If you don't know what the NIH is, I'm worried about you.
Q. Look at table 1 with me; would you. Take a look at it and take your time to familiarize yourself with it.
(Pause.)
A. I'm just looking at table 1.

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Q. You can go ahead and look at table 2, as well.
A. Okay.
Q. You see, in the fifth column, the one on the far right, it says "log rank P values for celecoxib." What's a P value?
A. It's a statistical calculation of events to try and ascertain if there's a significant difference between two bodies of data.
Q. It's a measure of statistical significance?
A. It's a value that -- the criteria for significance is that 95 out of 100 times you hit the result.
So, that means, a P value of 0.05 is regarded as statistically significant.
Q. So, anything above, in this chart, anything above .05 would indicate that there is not a statistically significant result?
A. Correct.
Q. Okay. Do you see, at the top of table 1, it says, "summary of CSUGIE incidence first six months."
A. I do.

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Q. Okay. On table 2 it says "summary of CSUGIE incidence entire study period."
A. Yes.
Q. What does it mean when it says "entire study period there"? How much time are we talking about?
A. It's those patients longer than six months.
Q. I'd like to go through this one by one.
If you look at table 1, for the first six months, under the log rank P values for celecoxib, do you see the column that says diclofenac, and then you see a P value, point 264?
A. Yes.
Q. That number indicates that the comparison between diclofenac and celecoxib was not statistically significant in terms of the number of CSUGIEs that showed up?
A. Is there a question?
Q. Is that correct, am I correct?
A. That's correct.
Q. I'm reading it correctly?
A. Um-hum.

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Q. If you go down to the next column, and you take out -- it says "patients not taking aspirin."
A. Yes.
Q. Am I correct that that little part summarizes, if you just take out all of the patients who weren't on aspirin, you're going to get a different number?
A. Correct.
Q. And for diclofenac versus celecoxib or Celebrex, that number was also not statistically significant?
A. Correct.
Q. And do the same thing for Ibuprofen.
Ibuprofen versus Celebrex, for all patients, again, not statistically significant?
A. You mean the .073 number?
Q. Yes, sir.
A. Correct.
Q. Okay. Now if you take out patients who are not taking aspirin, the .005 indicates that that was statistically significant?

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A. It's actually very highly significant.
Q. Okay. Now, if you combine diclofenac and Ibuprofen over the six-month period and you compare them to Celebrex, and you're talking about all patients?
A. Correct.
Q. You get .092 P value?
A. Correct.
Q. That indicates that there is no statistically significant difference between the combined NSAIDs and Celebrex in the study for CSUGIEs; correct?
A. Correct.
Q. Okay. So, it failed the primary end-point there?
A. And also, with aspirin, it would meet the primary end-point.
Q. Right. But you have to take out that has to be patients not taking aspirin, and that's .037; correct?
A. Correct.
Q. Okay. Now you go down to the entire study period.
A. Correct.

Q. And look at that column for Celebrex versus both NSAIDs, diclofenac and Ibuprofen.
A. Yes.
Q. Okay. For the entire study period for all patients, there is no statistical difference -- statistically significant difference between both NSAIDs and Celebrex in terms of the number of CSUGIEs?
A. Are you talking about the upper all patients first?
Q. Yes.
A. Correct.
Q. Okay. And the same is true if you go to the patients not taking aspirin?
A. No significance in diclofenac, significant difference with Ibuprofen, not significant with both.
Q. Okay. In fact, if you look at diclofenac, there was no statistically significant difference for any portion of the study between Celebrex and diclofenac?
A. Correct.
Q. And the only statistically significant difference in this column for

both was when you took six months of data and you had patients who were not taking aspirin?
A. Correct.
Q. Doctor, we had gotten into the discussion about the primary end-point earlier.
If you would turn to page 46 with me. Would you look at the fourth paragraph under -- there are some -- A, B, C, some bullet points. The first sentence in that fourth paragraph under those bullet points.
A. As stated?
Q. Right. So, it's --
A. Let me read it.
Q. Go ahead. Take your time.
(Pause.)
A. Okay, I read it.
Q. Okay. So, the primary end-point means upper GI bleeding perforation or obstruction?
A. Yes.
Q. I mean, that's a fair characterization? I think we were a little confused earlier.
A. Yes.

Q. Okay. If you will look at page 177 with me.
A. No other question on that paragraph?
Q. No.
A. 177?
Q. Yes. There's a table. It's table 10B. It deals with adverse events.
If you look at the title, it says "for the entire study period." This data is not for six months; is it?
A. That seems correct. May I peek at the data for a minute?
Thank you. I have.
Q. So that when it says "entire study period" there, it means more than six months; it means the whole, the entire period, the whole amount of time?
A. Correct.
MR. OLIVER: You can change the tapes now.
THE VIDEOGRAPHER: Off the video record at 11:07.
(Recess.)
THE VIDEOGRAPHER: Stand by. We're

back on the video record at 11:19.
MR. OLIVER: I will show you what is going to be marked as 234. Is that where we are?
(Needleman Exhibit 234, documents Bates Nos. 0219 to 0230, marked for identification as of this date.)
Q. Doctor, take a minute to look at this and familiarize yourself with it briefly.
(Pause.)
Q. Tell me when you're ready.
A. Okay. I reviewed it.
Q. This is an e-mail from George Geis to a number of people, including you.
It summarizes thoughts or ideas about the CLASS trial, prior to the actual start of the trial; is that correct?
A. Correct.
Q. Does it also indicate that there were discussions with FDA about the format of the trial?
A. The second paragraph says there were at least three discussions.
Q. Does it also indicate that the

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CLASS trial was originally planned to be six months?
A. Yes.
Q. Why did that change?
A. I still think it was an event-driven trial. So, one part of it, um, as described --
Q. Doctor, let me stop you. I'm going to move to strike as not responsive.
My question is: Looking at this document, do you have any idea why the trial went from six months to 12 months?
MR. HOFF: Objection to the form.
MR. OLIVER: What's wrong with the form?
MR. HOFF: It misstates.
A. I don't agree.
MR. HOFF: It misstates the evidence in the case, which he's told you 40 times. I can't even believe we're debating this issue right now, at this point in the case.
Are you actually seriously contesting that it's an event-driven study?

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MR. OLIVER: I don't really think that's the issue. I'm asking a question about this document.
MR. HOFF: Yes, it is the issue. And you asked why I objected.
MR. OLIVER: This is not productive. Let's start over, Doc.
Could you read back the question that was pending.
(Record read.)
A. I think it was an event-driven trial and that didn't change from this document to what the trial was.
Q. Would you look with me at the third page.
Actually, I'm sorry. Start on the first page. I'm going to read something to you. "The original design for the CLASS trial is shown in slides 1 and 2. It was planned as a six-month trial."
Do you agree with that statement?
A. You're reading -- I agree you read it correctly.
Q. Do you agree that that's what George Geis said in this document to you?

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A. The document says a lot more than that line.
It describes an early stop, which would be the event, and it describes stopping the study when nearly all the patients have completed six months. That's what it says.
Q. Turn with me to the third page, if you would. The second paragraph.
A. I have two copies of the first page. Do you mean this page?
Q. No, I mean the actual third page if you're just flipping. I have two copies of the first page, too. That's an e-mail chain.
A. The one that has "however."
Q. Precisely. "However, primarily due to the increase in the total number of patients and the requirement for a total of 2,000 patients participating for 12 months, the total cost of the two trials together is predicted to be $57,000,000."
Whose requirement was it that the study last 12 months?
A. I have to divide my answer.
Understand that's only 2,000 out of 8,000, not that the 8,000 go for more than 12

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months.
And the FDA doesn't require, in those discussions, there's a discussion -- and just like Merck could choose to do only one dose and one NSAID, that would be it.
So it is not a requirement in this, there's a discussion.
What's clear to me was not that the full 8,000 were going to 12 months, but just that some of the patients, 1/4th of the patients would go.
Q. The document does characterize it as a requirement, though; doesn't it?
A. It says that here, but that's not my perception of what the FDA says.
Q. Fair enough.
Do you remember any of this, the Power Point slides that -- does this ring a bell?
A. The specific slides don't, but this would be like many discussions we would have had.
Q. Okay. If you'll look with me at -- do you mean what I mean when I say a -- well, it's the fourth page, if you're just

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counting. Look at the fourth page. It says "original proposal."
A. Yes.
Q. And then, down the middle of the page, it says parallel group six-month trial.
A. Yes.
Q. So, this slide is summarizing what Searle originally envisioned the CLASS study to be?
A. But there are a lot of iterations of the design.
If you look, for example, there's an "approxinon." That's not part of the ultimate trial. So, this is the beginning of the discussions.
Q. And if you turn -- let's see, that was four, five, six, to the seventh page, it says celecoxib long-term arthritis safety study CLASS revised."
A. Okay.
Q. Are you with me?
A. Yes.
Q. So, this slide reflects -- as opposed to the original design, this slide reflects revisions to the CLASS trial that

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Searle implemented because of FDA's comments?
A. I don't think this is the final design. This is ongoing discussions.
Q. Okay. I accept that. But, at least at this point in time, there has been a revision to the study?
A. Part of the ongoing. And notice the word "FDA requests." That deals with your requirement earlier question.
Q. But it says FDA requests complete blinding of the study.
A. But it's not -- it's requires. That's just advice.
Q. FDA does have the power to require certain things; doesn't it?
A. No. In the end what they actually do is they say well, it depends upon the data. So, you have a certain latitude, as Merck did, in, for example, rejecting the aspirin patients.
Q. But the FDA has the ultimate authority to approve or disapprove of the label; correct?
A. They approve --
Did you finish?

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Q. Yes.
A. They approve or disapprove the final NDA.
Q. So, if Searle wants to get a drug approved, they would be wise to have listened to the FDA?
A. Advice is advice, and you decide, based on what you think about the trial.
Q. Okay. Flip the page with me. We were talking about the revised study. Flip two pages.
Do you see, at the top of the page, where it says new A?
A. I'm sorry? Yes.
Q. Are on the right page?
A. Yes.
Q. So, we're talking about, this slide is talking about the revisions as a result of the discussions with the FDA, and it's talking about the new A arm of the study. Is that accurate?
A. Yes.
Q. And then, under "design," it says what, first bullet point?
A. "Demonstrate that the risk of

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clinically significant UGIs."
Q. I'm sorry. Under the, by the word design.
A. Oh, design. "Double blind parallel, six to 12 months, OARA, no ulcer, h pylori status determined."
Q. So, this slide indicates, again, that there was a discussion with the FDA, and that discussion resulted in the trial being lengthened to 12 months.
MR. HOFF: Objection to form.
A. We established in the earlier page that the only discussion was 1/4th of the patients reaching 2,000 patients, that there was an event criteria, and the minimum was 6,000.
Q. Let's -- FDA required, or requested, depending on how you look at it, that some portion of the patients go 12 months?
A. I don't know who said that, but only 2,000 go, not the full, not the 6,000.
Q. According to this document?
A. According to the document.
Q. Okay. Flip to the last page.

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This slide is talking about the negatives and positives of the revisions that FDA had suggested; is that correct?
A. Yes.
Q. Look under "negatives," the second bullet point. "Risk that the pooled analysis will not be accepted by the FDA."
A. Yes.
Q. Do you have an understanding of what it means when it says "pooled analysis" there?
A. What I do know, if you're asking me my opinion is, the FDA did accept the rank order of analysis of the data, the first of which was pooled, that is Celebrex versus the combined, and if positive, then they would have done the unpooled.
Q. If you know, in this slide, why is it indicating that there was a risk that the FDA would not accept that?
A. FDA meetings are ambiguous, and each time you go -- and there were three meetings -- there's a different head of the FDA arthritis group, and there's different people.

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So, we take it as advice and we understand the risks, and the key risk, and the only firm decision comes on the NDA approval.
MR. OLIVER: This is going to be Exhibit 235.
(Needleman Exhibit 235, Power Point, Bates Nos. 11311 to 369, marked for identification as of this date.)
Q. Just looking at the first --
A. May I look at the document?
Q. Sure.
(Pause.)
A. Okay, I have the context. Let me just look and see if they have a Celebrex section.
MR. MONTGOMERY: It starts on the 23rd page of the document.
A. Why don't you go ahead now. I've got it.
Q. Okay. Do you remember this Power Point?
A. No. Not at all.
Q. But apparently, according to the first slide, Mr. DeSchutter was giving part

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of the presentation?
A. Mr. DeSchutter was not in Pharmacia very long. So, um, he took change of control and he, I was the only person within about six months who was a former Pharmacia Monsanto employee.
So, this must have been a very early, I think I remember just -- a couple of months and then he left. Maybe a month, even.
Q. If you'll look down at the bottom of the page, it says January 29, 2000.
A. Yes.
Q. That was before the merger of Searle and Pharmacia; wasn't it?
A. I'm not sure of the date.
I think it was March. It was the merger date.
Q. So, Mr. DeSchutter was participating in this presentation before the merger?
A. Correct.
Q. As was Ms. Cox?
A. I'm just surmising from the dates.
Q. Okay. If you will turn to page 3.

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The top of the slide says "questions on your mind."
Is it a fair characterization of this slide to say that it's discussing or talking about the merger between Searle and Pharmacia?
A. You know, I had nothing to do with this document, and I don't know what people were thinking in the document.
Q. Just based on your reading of it right now.
A. I don't know what to make of this.
Q. Okay. If you'll look at number 4, it says "Celebrex is a one-trick pony." Does that mean anything to you?
A. I don't know what these people are thinking about.
Q. At the time, January, 2000, do you recall what was happening with Celebrex's sales?
A. Are you asking me what I think was happening in general?
I think Celebrex has even greater potential than arthritis, and by that time we realized that COX-2 was expressed in every

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epithelial tumor.
So, I would have never agreed with the one-trick pony. I thought there were many other possibilities to Celebrex.
Q. But somebody obviously thought that was a possible impression?
A. I don't know what they thought.
Q. You don't have any idea why they would think that?
A. That -- I don't know why people think anything.
Q. Doctor, I'd like you to toss that exhibit. Put it aside.
I'd like to talk about the time period when the CLASS trial was coming to an end and you and others within the company, Searle and Pharmacia, were beginning to see the results of that trial. Earlier we had talked about the unblinding date of the CLASS data.
Has anything come back to you about that date? Can you tell me what that date was?
A. I don't know. All I know is you showed me the trial ended in March. Sometime

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after that.
Q. Okay. If I represent to you that the CLASS data was unblinded on March 17th, 2000.
A. I couldn't believe it if the last patient was March 17th.
Q. Well, do you have any reason to believe that I'm not telling you the truth?
A. Yes, because it's just impossible to crunch that much data on the day the trial ends.
You know, you have to go back and test the validity with so many sites, and there's a lot of things you do to scrutinize the quality of the data, and there are millions of case report forms.
It seems highly unlikely that on the day of trials you could break the blind, to me.
Q. Is it fair to say that the CLASS trial data was unblinded in the spring of 2000?
A. I don't know when it was. It was after the last patient.
Q. Was it in the year 2000?

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A. Sure.
Q. Was it at the end of the year 2000?
A. I don't know when it was unblinded.
Q. Okay.
Prior to unblinding, how was Searle tracking the data?
A. What I knew about was they knew the number of events and the data was blinded.
Q. Did somebody tell you that number on a regular basis?
A. I don't know a regular basis, but I know, as it reached a point in the upper numbers, there was a question of, does it, is there a rationale for going longer than what I thought reached 38 events.
So, I might have known the rate of events at some time.
Q. Do you recall having quarterly meetings about CLASS prior to unblinding?
A. No.
Q. Would it surprise you if there were quarterly meetings about the CLASS trial before unblinding?
A. I don't see the value, beyond the -- because you'll never break the blind. So,

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I don't see the value of quarterly meetings.
Q. Do you recall when you learned about the results of CLASS?
A. No. I mean, I don't know the date.
Q. Give me your best --
A. I don't know the date.
Q. Was it before June, 2000?
A. I don't know the date. It must be when the data was.
Q. How soon after unblinding would you have learned about the results?
A. I would guess when the data had been completely analyzed by statisticians, clinicians, and other people poring over the data and all the side effects, because it's not just efficacy, it's also all the side effects. So, some time period when the data was pretty well scrutinized.
Q. How long after -- I mean, give me an estimate of how long that would have taken.
A. I can't. Each kind of trial depends upon the end points in something.
Q. If the data is unblinded, is it going to be two weeks before you learn about

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the results?
A. Maybe I should be clearer for you, because we're not making progress. It's 8,000 patients. Each patient has hundreds of pages of data that's generated.
So, that all has to be analyzed, including the side effects. That's different with each kind of trial, and I don't, there is no cookie cutter number of days that I could tell you.
Q. Would you have learned about --
When you learned about the data, how long would it be before you would have shared that information with Mr. Hassan?
A. At some point, I knew we didn't hit the primary end-point.
That would have certainly come up in a discussion with Hassan.
Q. Would you have shared that before you had your monthly meeting with him?
A. I don't know.
Don't forget, when I'm in New Jersey, we're down the hall and see each other. So, I don't know.
Q. So, it's --

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A. It would be, um, sufficiently pertinent that when I would see him in New Jersey, after I had scrutinized and understood the data, that I would have told him about it.
Q. So, for sure, you would have told him at the monthly meeting, at the very least?
A. After the data was satisfactorily analyzed.
Q. But, it's possible that you even told him before that?
A. I don't remember.
Q. But, I mean, that's not my question.
A. I don't remember. I don't remember, because it would have required -- I'm in New Jersey, and most of the time I wasn't, I was either in -- so, I don't know.
Q. But that's a Yes to my question that it is possible; that's all I'm asking: Is it possible?
A. It's also impossible. I mean, it's a possibility. That's all.
Q. Okay. It's a possibility. We

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agree.
MR. OLIVER: I think we're on Exhibit 235.
(Needleman Exhibit 236, documents Bates Nos. 0614 to 27, marked for identification as of this date.)
A. I've looked at this.
Q. Do you see that the date is June, 1999?
A. I see that on the bottom.
Q. That was before the unblinding of the CLASS data?
A. What was the date that you showed me before? Wasn't that 2000 was the last --
Q. March 17, 2000 was the date.
A. So, the trial was still under way.
Q. So, that's a Yes?
A. Yes.
Q. Do you recognize this slide deck?
A. No.
Q. Turn with me to page 4.
A. Okay.
Q. It says "key challenges," and one of the key challenges, from an external standpoint, is the equivocal results of the

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CLASS trial.
Do you have any reason to understand why somebody would call the results of the CLASS trial "equivocal" in June of 1999?
A. No.
Q. Does it surprise you that somebody is talking about the results of the CLASS trial before the study is finished?
A. This is someone making a guess.
Q. How do you know that?
A. Because the data is unblinded and nobody could know the data.
Q. You said you don't remember this Power Point?
A. You asked me if someone before the data could make an assumption that is equivocal or not. That's purely a blind guess.
Q. So, it's not possible that the person making this presentation knew about the data of the CLASS trial?
A. No one --
MR. HOFF: Can I make a suggestion to clear this up?

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MR. OLIVER: Sure.
MR. HOFF: When was the date of the Pharmacia Monsanto merger? May of -- March of 2000; right?
MR. OLIVER: It was April 3rd, 2000, I believe.
MR. HOFF: Well, actually it closed March 31st. But that's not --
Why is this, then, you say Pharmacia? Pharmacia had nothing to do with it. I think the document is misdated.
MR. OLIVER: I think you're testifying, and I'm going to call the magistrate.
MR. HOFF: I'm just telling you -- you know what -- okay, fine. You know, ask your questions, because it's your minutes.
MR. OLIVER: That's right. It's my minutes.
MR. HOFF: What a waste of time.
THE WITNESS: The last page?
MR. HOFF: Right. Go ahead, ask your question.

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A. My answer was -- my answer is: No one knows the data until the data is unblinded. No one.
Q. Would you look at page 9, slide deck 9.
Are you there with me?
A. Yes.
Q. It says "governance structure," and it indicates, under PHA, Fred Hassan, Phil Needleman, Carey Cox and Tim Rothwell; is that correct?
A. It certainly says it was after the Pharmacia merger. Yes, that --
Q. I'm asking you what it says there.
A. The governance -- it shows two sides. It has the people on the Pfizer side, people on the Pharmacia side.
Q. Okay. And you were under the Pharmacia label at that point?
A. That's what this slide would suggest.
Q. Even though it says "corporate strategic plan, June, 1999," which, as your lawyer testified, was before the merger?
A. This can't be right (holding

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exhibit). Because it doesn't even have deSchutter. You could keep going after on that. If it wasn't after the merger, it would have had deSchutter. You just are wrong.
Q. But, I mean, you don't have any reason to --
Strike that. You can't tell me how this document is wrong?
A. I certainly can.
Q. You're not aware of, nor have you talked to anybody who has told you that they modified this document?
A. You're the one who presented the document. It says, under the Pharmacia side, does not include deSchutter. If it was beforehand, it would have been deSchutter.
Q. I want to strike that answer as --
A. And it wouldn't have had Tim Rothwell on this.
Q. I'll move to strike that answer as non-responsive.
Listen to my question.
Do you have any specific evidence that someone misdated this document?

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A. No.
Q. You can put that one aside, now.
Doctor, if you will pick up the final report for me again. On page 1 you had indicated that it says study dates, September 23rd, 1998 to March 17, 2000. Do you see that?
A. Yes.
Q. And you had said that that meant that March 17 was the last patient date, I guess.
A. That's what I assume.
Q. Okay. Would you turn with me to page 55. Take a second just to read that page.
(Pause.)
A. Okay. I've read the paragraph.
Q. Okay. If you'll look at the, that large paragraph in the middle, the last two sentences, you mentioned earlier that Searle decided to end the study early. The sentence beginning with "Therefore" --
A. Yes.
Q. That's what that sentence is talking about, the decision to end it early?

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A. Yes. I don't remember what GEC is.
Q. Look at that last sentence: "All investigative sites were notified of this decision on December 9, 1999." When it says "this decision," it means the decision to end the study early?
A. I think that's what that means.
Q. Okay. And then it says, "And ask to schedule final visits for all remaining patients to take place by January 7, 2000."
A. Yes.
Q. So, if all patients had their final visit by in or around January 7, 2007 -- sorry -- January 7, 2000, is it possible that the data was unblinded in March of 2000?
A. I don't know the dates. It's possible. As long as all the data was in, and then it was crunched, it's possible.
Q. Okay. We can put that down for now. What exhibit are we on, 237?
MR. HOFF: That's the next one.
(Needleman Exhibit 237, document Bates No. 02847743 , marked for identification as of this date.)
Q. Let me know when you're ready,

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Doctor.
A. Okay, I've read the document.
Q. This is an e-mail, March 26th, 2000, from George Geis to a number of people.
A. Yes.
Q. And you're on the e-mail chain down below; is that correct?
A. Yes.
MR. HOFF: You're referring to the last --
A. This is an earlier --
MR. OLIVER: Correct.
A. I wouldn't have seen the above note that was not to me. The lower note was just the scheduled meeting.
Q. Right. Okay. For the March 26th e-mail, the title, or the subject, says "special SMB meeting."
A. Yes.
Q. What's the SMB?
A. Senior management board.
Q. Who was on the senior management board?
A. The heads of the R&D functions who reported to me, clinical, discovery,

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regulatory, pre-clinical, that kind of safety.
Q. What about Mr. DeSchutter?
A. No.
Q. Mr. Hassan?
A. No.
Q. Ms. Cox?
A. No. This is an R&D committee.
Q. You see the first sentence, it says "As per the note below, Phil wants us to present CLASS on Wednesday."
A. Is there a question?
Q. Is Phil referring to you?
A. I think so.
Q. So, that means you wanted this group of people to present the CLASS data on Wednesday, March 29th?
A. Yes.
Q. So, the CLASS data would have had to have been unblinded by March 29th, at the very least?
A. Correct.
MR. OLIVER: You can put that aside for a second.
I'm sorry, Doctor. Pick that up

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again.
Q. Do you see where it says, "Jim, do you want to distribute the main presentation to the addressees of this note"?
A. Yes.
Q. What does he mean "the main presentation"?
A. I don't know.
Q. Is it possible he's referring to a Power Point?
A. I don't know.
Q. Is it likely?
A. I don't know.
Q. In your experience?
A. I don't know.
Q. Okay, you can put it aside now.
Doctor, this information was ready for a presentation to the senior management board by at least March 29; correct?
A. Correct.
Q. At that point, would the information have been polished enough to present to Mr. Hassan?
A. I don't know until I see the data.
It would not have been the place

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for Hassan. It would be a pretty deep technical review.

It would probably be the beginning of several. So, I could only, um, suggest that it would be much earlier than a discussion with Hassan.

Q. You would have probably talked to him about it at your monthly meeting, though?

A. Um, I would have first studied the data.

(Exhibit 65, CLASS vignettes 3/28 version (previously marked), marked for identification as of this date.)

MR. HOFF: Let's just call it Exhibit 65.

MR. OLIVER: That's fine.

MR. HOFF: And we'll take it back.

Q. Tell me when you're ready, Doctor.

(Pause.)

A. I just scanned the early part.

If you dig into the later part, I'll have to look at it a little more closely.

Q. Perfectly okay. I understand that.

The e-mail that we just discussed,

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I believe it was the former Exhibit 66, when Mr. Geis talked about a March 29 presentation.

This presentation is dated, or this version of this presentation is dated March 28, 2000.

Is it possible that this is the same presentation that was discussed in the e-mail?

A. Um, I don't understand why they would say "vignettes," and there's much more here than would come up in my request for a data analysis. So, a lot of this would have been inappropriate for my request.

The parts of it where they have data would have been the objective of the meeting, not planning about meetings, presentations, and that kind of thing.

And it wouldn't have been called "CLASS vignettes."

Q. But it does deal with the CLASS data?

A. Some of it does.

Q. Turn to page 3 with me, if you will.

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MR. HOFF: Did you say that the e-mail was formerly marked as 66?

MR. OLIVER: Wasn't that 66? Or is that 66?

MR. HOFF: No. No. No.

MR. OLIVER: Or is it 66?

MR. HOFF: The vignettes are 65.

You guys have got to talk to each other.

The e-mail is 237. I just want to make sure that the record is clear.

MR. OLIVER: Okay. That's fine.

Q. Slide 3, Doctor, "dissemination of CLASS data."

This slide indicates that the CLASS data would be disseminated to Searle Pharmacia CLASS study team by April 3rd, 2000; do you see that?

A. Yes.

Q. Commercial leadership by April 7th, 2000?

A. I see that written there.

Q. And all clinical by April 5th, 2000?

A. I see that written.

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Q. When it says "commercial leadership," who would that refer to?

A. Um, I don't know who is writing this, but I would guess it's the people involved with sales, marketing, and so on.

But this seems to be a document presuming what would happen in my data review, and then that would have been the decision how much we understand it before it moves forward.

Q. At least at this point, the plan was to disseminate the data on these dates?

A. I don't know who wrote this; so, I don't know what they're thinking. I think they're probably assuming that the data will be so clear that everything would move forward.

Q. Would Mr. Hassan be included in the commercial leadership?

A. Yes, I would say that would be a fair assumption.

Q. What about Ms. Cox?

A. Yes.

Q. Which group were you in?

A. Um, if you look in 237, I'm still

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the head of R&D, and there's going to be a data analysis --
Q. No, but would you have been in one of those groups in the bullet points, or had you seen the data by the time this was drafted?
A. It looks like I don't see the data, except from your Exhibit 237, in the meeting that was going to be on March 29th.
Q. So, by at least March 29th you had seen the data?
A. I'm presuming that meeting came forward --
Q. Okay.
A. -- but this would not have been the document.
MR. HOFF: And when you say "this," you're referring to Exhibit 65?
THE WITNESS: 65.
MR. HOFF: It's the vignettes.
THE WITNESS: Mine says 29 or 238.
MR. HOFF: But we're calling it 65, but it's the vignettes.
THE WITNESS: May I have a new label?

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MR. OLIVER: You tell him what's going on.
MR. HOFF: Off the record.
(Discussion off the record.)
BY MR. OLIVER:
Q. Would you look at slide 4, if you would, Doctor. It says "publication strategy."
Tell me what you think this slide is talking about.
A. I think that this team is making a guesstimate of where to submit the data.
Q. Why would they submit the data to anyone?
A. It's a very important therapeutic issue, and there are certain things buried in the data, either beforehand or afterwards, which are very, very important.
Q. Important from a clinical standpoint?
A. Important from a clinical standpoint.
Q. What about a commercial standpoint?
A. It's the clinical part that's more important than the commercial part.

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Q. Does the clinical drive the commercial?
A. Why don't we zero in on what I think is important then, that aspirin data is very profound.
Q. But, Doctor, let me interrupt you. I'm sorry, that's not my question.
Does the clinical practice of physicians drive the commercial success of the drug?
A. Of any drug it does.
Q. So, it's important to submit the data for publication to let the doctors know what's going on for clinical reasons, but also for commercial reasons?
A. The doctors don't decide because of commercial reasons. And this is a journal where they want to know the clinical data.
Q. You're telling me no doctor makes a decision about treatment based on commercial reasons?
A. Yes. That's what I believe. That would be the proper, the proper practice of medicine: what's good for my patients, not who makes money.

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Q. But that doesn't mean that every doctor follows that?
A. That's -- you asked me a question, and I answered it.
Q. Sure. If you'll look at the second bullet point under JAMA, what is JAMA?
A. The Journal of the American Medical Association.
Q. The second bullet point says "six-month efficacy general safety and labs."
Is it fair to say that whoever was presenting this had decided that JAMA was going to get six months of data?
A. You're asking me to guess about the -- I think this is the beginning of the discussion of what should be in that data.
Q. So, at this point, on March 28th, somebody had suggested that it be six months of data?
A. Correct.
Q. Was that person you?
A. No.
Q. Were you involved in that decision?
A. Are we talking --
MR. HOFF: Which decision?

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Q. The decision to submit six months of data to JAMA.
A. Are you talking about this document, or the discussion about the JAMA? So, I need more from you.
Q. I need more from me sometimes, too, Doctor.
A. Life is hard.
Q. The decision, in general, to use six months of data for JAMA, were you involved in that decision?
A. Um, I was ultimately aware of what was submitted, and I was aware that it was the six-month data.
Q. Were you involved in the decision to submit six months of data?
A. Um, the way publications work, um, and especially because publications also involve clinicians and scientists outside of Searle, I let them decide, I just have to be satisfied about the data and the correct -- and the decisions in the data.
So, that's, that's a decision that also involves external, the external advisers, who the authors are.

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Q. So, if there were meetings to discuss the use of the six-month data, for the JAMA article, you would have been at those meetings?
A. It would have been at some meeting where that was a discussion.
Q. You would have contributed to the discussion?
A. If I had something to contribute, or I would see if I was convinced or not.
Q. Do you recall expressing an opinion on six months of data versus 12 months of data for the JAMA article?
A. I have an opinion about the six- or 12-month that has, it's not just the JAMA article; so, that would have been a discussion.
Q. That's not my question. I move to strike that as non-responsive.
My question is: Do you recall expressing an opinion about that for JAMA, for the JAMA article?
A. I don't recall.
Q. Do you recall any meeting at all where -- I mean, specifically recall any

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meeting where you discussed that?
A. Would you say if you are talking about JAMA or not?
Q. I'm talking about JAMA?
A. I don't recall that discussion.
Q. If I'm not talking about JAMA, do you specifically recall discussing it?
A. I understood the issues about six months versus 12 months with time.
I don't know when that happens relevant to when they're preparing the JAMA document.
Q. Do you think you would have received a draft of the JAMA article before it was submitted?
A. Probably so. Yes.
Q. The same exhibit, if you will look with me at slide 7. This slide is entitled "regulatory strategy."
Why is the regulatory strategy different from the publication strategy?
A. I can only guess.
We missed the primary end-point, and we were well aware of it.
Q. Why do you have a different

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strategy for publications than you do for regulatory bodies?
A. I don't know that that's true.
Q. Okay. This slide is at least talking about regulatory strategies; correct?
A. Different than the Journal, yes.
Q. And it deals with discussions of FDA -- excuse me, with FDA.
A. Yes. And that's not the NIH.
Q. That's right; it's not.
If you look down at the second bullet point, it says, "appropriateness of six-month sensoring."
A. That -- mine says "achieved agreement on revising analytical" -- am I on the right page?
MR. HOFF: He's talking about the bullet point, rather than the dash point.
A. What are you talking about?
Q. The very bottom bullet point, the last writing on the page.
MR. HOFF: Yes.
A. Yes.
Q. Did somebody question the

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appropriateness of submitting six months of data to the FDA?
A. Somewhere in the --
MR. HOFF: Objection to the form.
A. -- in the analysis --
Q. You can answer, Doctor.
A. Somewhere in the rigorous analysis of the data after the blind, the data clearly suggested a higher dropout rate of diclofenac patients, based on some of the symptomatic data, and the realization that that data could have caused the loss of the high risk patients.
And so, that whole question is how you handle that dropout rate, would, for me, have been embedded in the sensoring question.
Q. The question that was asked in that slide at least, as reflected in your discussion, was whether it's appropriate to use the six months of data or not.
A. The question in that slide is about the discussion with the FDA, which, in fact, ensued about the appropriateness of that selection, the appropriateness of that sensoring of data.

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Q. You will agree with me, then, that there was at least some concern that this may be appropriate, it may be inappropriate, we need to talk about it?
A. We had no belief that we ever hit the primary end-point. We also, and the FDA, didn't understand several issues. This was one. The other was the very confounding effect of aspirin.
We felt that the data speaks for itself and the FDA should review the data, and that should be the basis of their decision.
Therefore, we thought that there was a possibility that we could still get approval on that label.
Q. Your strategy was, then, to present the full gamut of data to the FDA, six months, 12 months, everything, and let them make the decision?
A. There should be no surprise. Every bit of data must be presented to the FDA.
Q. Would that be different for publications?
A. Sure. Publication doesn't have to

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do with what's submitted to the FDA.
Q. What about -- so, you're telling me FDA gets the full data, but the public does not get the full data?
A. Manuscripts have a mission, a target, a set of scientific event that doesn't have to do with the FDA. That has to do with -- the FDA has a different kind of criteria.
They absolutely have to have a consideration of what should go into general practice.
People who read journals want to understand mechanism, side effect, and the totality; and so, it's a different question about what's in a publication and what's in the FDA.
Q. You have to submit the full data to the FDA, as you just said?
A. Correct.
Q. But you don't have to submit all of that data to the public?
A. You don't. Publications aren't equal to the FDA submission. They're some part of what you want to present about the

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patients and data.
So, I've never seen a publication that has the FDA submission -- never, as something that's in a journal like JAMA or any other journal.
Q. We'll come back to this.
Look at slide 16, if you would.
Tell me when you get there.
A. It says 12-month data.
Q. At this point, on March 28th, the date of this draft presentation, you agree that there was a clear dichotomy between six-month data and 12-month data?
A. That's an incomplete question.
I understood what the six-month data, I understood the 12-month data, and I understood the implications.
Q. On March 28th, 2000?
A. I don't know the date.
Q. That's the date of this Power Point.
A. I don't know this Power -- I don't know something that would say "vignettes"; so, this may or may not be what I saw on your 237.

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Q. Well, whether you saw this Power Point or not on March 28th, by March 29th you would have certainly known about the difference between the six- and the 12-month data?
A. Whenever that was presented. Yes. I think that would be right.
MR. OLIVER: Do you know when you want to take a lunch break.
MR. HOFF: We ordered food in.
Off the record.
(Discussion off the record.)
MR. OLIVER: This was previously marked in another deposition, I'm certain of it. But we may just have to mark it again, unless you know what number it is.
(Needleman Exhibit 238, documents Bates Nos. 8910 to 9013, marked for identification as of this date.)
Q. Take a minute to look at this document. I think it will probably go quicker if you wait to just generally look over it and see if you read it.
A. I'm going to first look it over a

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little bit.
MR. OLIVER: Good.
(Pause.)
Q. Doctor, while you're looking at that, you had said earlier that you were not sure if the data for the SMB meeting on March 29th would have been polished enough to present to Mr. Hassan?
A. Yes. That would have been premature.
Q. Okay. Was the data in the Power Point that you just saw --
A. I'll have to --
Q. The previous one. Was that polished enough to present to Mr. Hassan?
A. I didn't study it that hard.
My kinds of meetings are much more intense; so, we would have needed a lot more.
There would have been a lot of discussion, and I would have not had, it would not have not been ready to present to Hassan.
Q. You would have discussed it with him?
A. Only when I was satisfied that we

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understood all the data and we had scrutinized the data.
And his kind of meeting -- at some time or other, the information that's pertinent for him is we missed the primary and we're analyzing the data.
I'm sure you'll have a lot of specific questions that we'll have to go into.
Q. Do you recall this Power Point?
A. You know, I don't remember specific ones. It looks like the kind of presentations that I would be a recipient of.
Q. So, is it possible that this was the Power Point that they were talking about, or version of the Power Point that they were talking about in that e-mail?
A. It is, but I do notice it's April the 3rd, instead of March the 29th, but it's possible.
Q. If you'll look at slide 71 really quick with me.
A. I'm sorry. But some -- I've lost the numbering in these things.
MR. HOFF: It will be here.

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MR. OLIVER: Off the record.
(Discussion off the record.)
MR. HOFF: There you go.
A. So, it says "Phil." I know that guy.
Q. And that's you?
A. I guess.
Q. Does that indicate to you that you saw this presentation, or participated in it?
A. That could indicate that's what they're going to present to me; so, otherwise, I don't think you'd have to put my name on it.
Q. Is it safe to say that, one way or another, you saw this?
A. I'm familiar with some of the data, yes; so, sometime or another, I would have reviewed data like this.
Q. Do you know if Mr. Hassan would have seen something like this?
A. I don't think he would have.
Q. Why do you say that?
A. It's too technical.
Q. What about Ms. Cox?
A. No. Definitely not.

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This data is terribly interesting. Take a look at this -- (pointing)
MR. HOFF: Answer the questions.
Q. If you will look at slide 39 with me.
A. I'm at a loss about numbering.
Q. It's down in the lower-left-hand corner under the line.
A. Well, there are many pages I have haven't got any number under there. It picks up at page 75 again, so --
MR. HOFF: Can you refer to the Bates number?
MR. OLIVER: It's Bates number -- do you know what I mean when I say Bates number, Doctor?
MR. HOFF: It's the other number, and every page will have that.
A. These things, no.
Q. If you go to 01238948.
A. 8948.
Q. Yes, 8948.
A. Got it. It just says "12-month data."
Q. So, that's the same or similar

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slide that we saw in the last Power Point?
A. I don't remember. Do you want me to look?
Q. No. That's okay. Turn the page.
A. Okay.
Q. So, once again, we've got 12-month data; correct?
A. Yes.
Q. And each little star on these bar graphs indicates that there was a statistically significant difference; is that correct?
A. Correct.
Q. -- between Celebrex and whatever the bar graph happens to be comparing it to?
A. Yes.
Q. And when you go to "UGI complications," which was the primary end-point, there's no star because it wasn't statistically significant?
A. Correct.
Q. And you go to "complications plus ulcers," and there is a star?
A. Correct.
Q. And you're talking -- you have a

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graph that does all patients, and you have a graph that does non-aspirin users?
A. Yes.
Q. At what point do you remember making a decision to combine the analysis to look at UGI complications plus ulcers?
A. At some time or other, when the team brought the data forth and showed including ulcers, to explain the data we missed the primary, we really thought it should work.
And then they brought forth more of the sub-analysis, the withdrawal rate, the symptomatic; so, that would have been a discussion when --
Q. You missed the primary end-point, and after you figured out that you missed the primary end-point, you decided to look at something else?
A. Yes -- you do a deeper analysis of why did you miss.
Q. Why did you combine ulcers and ulcer complications?
A. Looking back, especially knowing about the high withdrawal rate in dilofenec,

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they were quite aggressive in dropping out patients who had symptomatic ulcers.
So, it was before they reached what you're calling here "UGI complications."
Q. Would you look at slide 76 with me.
A. Give me your -- what do you call it the Bates number?
Q. Bates number.
A. B-A-T-E-S?
Q. B-A-T-E-S. The Bates number is 01238985. 8985.
A. Okay.
Q. Do you see the third bullet point, it says, "FDA may be reluctant to accept the data for a label change."
A. Yes.
Q. Can you recall why somebody thought that the FDA would be reluctant to accept the data?
A. Let me look.
I think any time you miss a primary end-point the FDA would be reluctant to change.
You'd have to really make a pretty compelling case to get them, when you --

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because it's a prospective design. It would be true of any drug.
Q. This was a significant issue for Celebrex, the getting the label change?
A. It's a significant on any drug where you miss the primary.
Q. Is this the kind of issue that Mr. Hassan would have discussed with you?
A. No. This is my job.
Q. You wouldn't even have told him about it, given him the heads-up?
A. Um, there might have been a discussion.
I ultimately am pretty convinced it's a fair discussion of two issues with the FDA, and the two issues are, confounding data of the aspirin, because it was a much higher rate than we previously experienced.
And the withdrawal of the high-risk patients with diclofenac.
Q. And these are issues you would have discussed with Mr. Hassan?
A. No. With the FDA.
Q. What would you have told Mr. Hassan about the prospects of a label change?

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A. We missed the primary end-point and we're continuing to analyze the data, and it's my belief that we have a sound scientific reason to come and debate with the FDA and the advisory committee, about what we thought was the important reason.
You see, you go into a trial and there are unknowns.
Q. So, you would have told him that there were important issues that you had to press or debate with the FDA, you would have discussed those reasons?
A. No. I don't remember.
What still stands out in my mind, is we missed the primary end-point, and we thought that we could really make a case to the FDA, because I believe that the, as reflected in the six-month data and not changed by the 12-month data, there was a rational basis for approval.
That's further clarified because the Vioxx data eliminated the aspirin, and that eliminated the major confounding, and they only had one comparative.
So, it was my belief -- so, Hassan

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would, he would not have poured over the data. That's my decision.
Q. You would have told him, though, that the case you would make to the FDA is X?
A. No. I don't know what I would have -- I would have told him, there's data that's relevant for the FDA. We wouldn't have poured over the data.
Q. You would have given him the general parameters of the discussion?
A. No. We missed the primary, and the rest is negotiations with the FDA.
Q. When you say to Mr. Hassan we missed the primary end-point, he doesn't have any follow-up questions?
A. I don't recall.
You know, when you do drug trials, it's not a rare event that you miss the primary or the secondary. That's still a work in progress that goes on for weeks and months with the FDA.
Q. Celebrex was hugely important to the company at the time?
A. Yes.
Q. You tell Mr. Hassan that you missed

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the primary end-point. You don't think he would have asked you a follow-up question?
A. You could spend all day pursuing this. I don't think so.
I think he would have been satisfied with my judgment, we missed the primary, and we're going to go over the data with the FDA.
MR. OLIVER: That's all I have on this document. If you want to break for lunch.
MR. HOFF: Yes. Why don't we do that.
THE VIDEOGRAPHER: Off the video record at 12:43.
(Luncheon recess: 12:43 p.m.)

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AFTERNOON SESSION
1:16 p.m.
P H I L I P N E E D L E M A N, having been previously sworn, resumed the stand and testified further as follows:
EXAMINATION (cont'd)
BY MR. OLIVER:
THE VIDEOGRAPHER: Stand by. Back on the video record at 1:16.
MR. OLIVER: Doctor, take a look at what, I guess, we're going to Exhibit 239 now.
(Needleman Exhibit 239, documents Bates Nos. 5044 to 45, marked for identification as of this date.)
Q. Tell me when you're ready.
A. Okay, I've looked at it.
Q. If you look, this is an e-mail chain.
And if you look at the third e-mail down, dated April 5, 2000, from Goran Ando to you, and Michael Friedman.
A. I see it.
Q. Okay. I'm sorry. Look up at the top, the very first e-mail. It says,

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"Everyone FYI after the presentation at Peapack."
Do you see that?
A. Yes.
Q. And that refers to Peapack, New Jersey, the head of Pharmacia's operations?
A. Peapack is where -- but that also could have been where I had the SMB meeting. I don't know that.
Q. Okay. But it would have been at the corporate headquarters?
A. Yes.
Q. Okay.
And there was, obviously, a presentation of the CLASS trial data at Peapack?
A. Yes. That's what it looks like.
Q. Okay. Now, back to the e-mail. This is Mr. Ando, or Dr. Ando providing some thoughts on the data that was presented to him; is that correct?
A. Yes.
Q. Look at number 2.
He says, "For the first public disclosure of data it might be worthwhile

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thinking through whether: A, only showing results of NSAIDs combined; or B, only showing results versus Ibuprofen makes sense. I guess the answer is probably No, but it's worth going through the exercise formally."
First, do you remember this e-mail?
A. No.
Q. Do you agree with me that, at this point, there had been no public disclosure of the CLASS data?
A. I think that's correct, yes.
Q. Mr., Dr. Ando, Mister or Dr., whatever he is, is suggesting a certain way to release the information for the first time?
A. Yes.
Q. Why does he suggest only showing the results of "NSAIDs combined"?
A. I don't know why he makes suggestions.
Q. What does that mean to you, that A?
A. This whole note is about how to strategically handle it.
Some parts of his suggestions I would agree with, some parts on the whole

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thing, some I wouldn't. This is just the beginning of the discussion.
Q. Do you remember, at the time, agreeing with A?
A. You know, I'm more familiar with agreeing with what went into the JAMA paper than his note.
Q. Okay, look at --
A. And parts I disagree with. But I actually agree with number 3, very much.
Q. But we're talking about number 2 now.
A. I know. Parts of it I agree, parts not. This is advice that goes into the discussion.
Q. Look at B, "only showing results versus Ibuprofen."
A. Um-hum.
Q. Why would he make that suggestion?
A. Looking at the data, if you looked at Ibuprofen, and took out the aspirin, it would look like you did find, I think that's overzealous, and it's a -- misrepresents the data. So, I don't think that's a -- for me, that wouldn't be scientifically acceptable.

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Q. Do you recall rejecting this suggestion?
A. I don't even recall this whole note.
Q. But from what you're telling me now, you would have rejected that suggestion, because it --
A. That would have been a discussion, yes.
Q. Is that why he said --
A. I would have rejected just talking about the thing that only worked, and I think we never, ever didn't agree that we missed the primary end point, and I think that's the important thing.
Q. I think that's it for that one.
MR. OLIVER: 67.
Q. Take a second to review this and let me know when you're ready.
(Pause.)
A. Okay. I've read it.
Q. What is it?
A. It looks, to me, like some kind of a press release, it looks like, from investor relations, from the top of it.

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Q. What's the subject matter of it?
A. It's some kind of a report from the top on the CLASS trial.
Q. In the e-mail we looked at a moment ago there was discussion about the first public disclosure of the CLASS data.
Do you know if this was the first public disclosure of the CLASS data?
A. I have no idea. I don't know. The dates, over here it says April 17th.
Q. Is this something you would have reviewed?
A. No.
Q. Are you sure about that?
A. Yes. I'm pretty sure.
Q. Why do you say you wouldn't have reviewed it?
A. I'm not interested in the marketing and business parts, I'm interested in the FDA part and the scientific journal part.
Q. Is this something that Mr. Hassan would have reviewed?
A. I don't know.
Q. Is this something that Ms. Cox would have reviewed?

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A. I don't know. I would guess, maybe so.
Q. Based on your experience, is that maybe so for both Mr. Hassan and Ms. Cox?
A. No.
Q. Just for Ms. Cox?
A. I'm only guessing, because she's the head of U.S. business. It's just a guess. I don't know what she reviewed and what she didn't.
Q. Why do you think Mr. Cox -- I mean, excuse me, Mr. Hassan would not have reviewed this?
A. I think that's below his screen, also. He knows that there's going to be an FDA advisory committee meeting at some time or other, so.
Q. Look at the third paragraph with me, under the heading "groundbreaking study reflects real world practice."
It says, "The CLASS safety study," or -- it says --
A. The whole paragraph?
Q. The third paragraph, first page, the third whole paragraph under that bold

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heading, "The cellecoxib long-term arthritis safety study" -- that's CLASS -- "an approximately 13-month, multicenter, randomized, double-blind outcomes trial of about 8,000 arthritis patients was designed to mirror everyday clinical practice by enrolling a broad spectrum of patients," and it goes on.
So, you would agree with me that this press release says CLASS lasted 13 months?
A. No. Where do you see that?
Oh. Oh.
Look, I know the trial stopped because of the number of events. There might have been some patients that reached 13 months, but a lot of them that didn't.
Q. So, do you agree with me, or do you not agree with me?
A. Say it again.
Q. Do you agree with me that this press release characterizes CLASS as a 13-month study?
A. Um, all I can do is see what I read. That's not what -- the FDA is the real

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arbiter, and they will see the data for what it is.
Q. Let me ask the question again.
Do you agree with me that this press release characterizes the study, CLASS, as a 13-month study?
A. All I can tell you is what I read, and that's what it says, but that doesn't reflect the data, as I know it.
Q. Do you see anything in there that talks about the six-month data? Take a minute and review it.
A. In that paragraph?
Q. No. I'm sorry, in the whole thing.
A. I can't tell what, when it's talking about it.
I can't tell in here how you would decide what duration that he's talking about.
Q. But take a minute and just tell me if you see anything in there that says anything about the six-month data that you were talking about.
A. I don't know what it -- you know, I don't know where it says how long the data is. I'm looking for it, and I'm not finding

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it. Do you want to point it to me so that I can see it, where it says --
Q. I already pointed you to the only part.
A. Well, that's someone who doesn't know very much about, and that's not someone who would have been writing papers or presenting to the FDA.
Q. So, they've gotten it wrong in this press release?
A. If they think it's a 13-month trial, they've got it wrong.
Q. Okay. Turn to the second page, if you don't mind, with me. This is the third paragraph on the second page.
And this is -- I'm not a scientist, so this is going to be tough for me, I'm going to need you to walk me through it; all right?
A. We'll try.
Q. Okay. I want you to look at the first sentence.
A. The study?
Q. Right. I'm going to read that out loud: "The study funded by Searle and Pfizer

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Incorporated found that Celebrex patients experienced significantly fewer symptomatic GI ulcers and ulcer complications compared with Ibuprofen or diclofenac."
What does that sentence mean to you? Explain it to me.
A. The sentence is combining the end-point, and they're comparing it to the two NSAIDs -- that's what it kind of means, somewhere else I had read it said the combined data.
So, I might have written it differently at the end, but fortunately in the earlier part I read something that, here in the -- a difference that was statistically --
Q. Doctor --
A. -- it was on the combined data.
You asked me what I thought, so -- I read it in the context of what I read in the beginning, which is, they looked at a combined end-point, including symptomatic, and I understood it in the context of the earlier statement. That's what I thought.
Q. Give me that one more time.

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I've completely missed your answer. I didn't get your answer to my question: What does it mean to you?
A. It means to me that --
Q. I'm sorry, Doctor. Strike that.
A. Start all over.
Q. What are they comparing, Celebrex versus what? What does that sentence indicate there's a comparison of?
A. I read that sentence in the context of the whole document. And the whole earlier document said they did the combined data.
If I were writing that sentence, I would write it differently. I think it's not a good choice of language, that sentence.
Q. What would you do differently, if you were writing it?
A. I would re-emphasize that it's the combined data. I would have said "and" instead of "or." They said it in the beginning, but it would have been worth re-emphasizing it, if I were writing it.
Q. Why would you reemphasize that, if you were writing it?
A. Because it's, it's not the context

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of what the actual measurements are made, as described in the opening sentences.
Q. So, it's confusing.
A. Yes. It's not a good choice of language.
Q. If you look at Celebrex for the combined end-point, the GI ulcer complications plus symptomatic ulcers, if you look at Celebrex for the combined end-point and you compare it with Ibuprofen, was there a statistically significant difference?
A. With or without aspirin?
Q. Let's start with the six-month data.
A. Without aspirin, the answer is Yes.
Q. With aspirin?
A. Um, I think not.
I think with aspirin, the Ibuprofen was -- I mean, so, I think without aspirin is where it had the -- no, the significance got better. I'm not sure we went over those numbers.
But Ibuprofen, all patients.
Q. If you want to look back at exhibit, it's Exhibit 65.

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MR. MONTGOMERY: 66.
MR. OLIVER: The final report, it's page 6. It's tables 1 and 2.
THE WITNESS: Good.
A. It was .09.
Q. I'm sorry. Dockets. It's page 7. It's, I said tables 1 and 2, it's tables 3 and 4. It's the next page.
(Referring to Exhibit 14)
Q. That's the combined end-point data.
A. So, it is significant with Ibuprofen at six months. P.005.
Thanks for pointing that out. And with aspirin it's even better.
Q. And with diclofenac --
A. It's not significant.
Q. So, if you look at them separately, and you compare them, diclofenac, there's no statistical significance with the combined end-point when you compare diclofenac?
A. That's correct.
Q. Okay. Look at the second sentence for me. Keep that near you, if you need to refer to it.
A. The second paragraph?

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Q. The same paragraph, right, the next sentence right after that.
A. I'm sorry. Get me back there.
Q. You're on the second page of the press release, it's the --
A. The one that says "the study"?
Q. The third paragraph, "the study," and you want to go to the second sentence, which is: "Celebrex was associated with."
A. "Numerically fewer ulcer complications compared to -- a statistically significant difference."
Okay. What's the question?
Q. I want you to focus on the second part of the sentence.
It says, "64 percent fewer of these serious events among non-aspirin users, a statistically significant difference."
In that sentence, when it says, "these serious events," it's referring to ulcer complications; correct?
A. I don't know. Let me --
So, you want to refer me now to a table?
Q. No. I want you to read the

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sentence first. This question is just -- in that sentence, when it says, "64 percent fewer of these serious events," it's referring to ulcer complications?
A. I think you're right. It says Celebrex was associated with fewer ulcer complications; I think that's correct.
Q. Among non-aspirin users.
A. Yes.
Q. Look at tables 1 and 2, with me. That was page 6, again.
A. Okay.
Q. Can you tell me if that sentence is referring to the six-month data or the 12-month data? Table 1 versus table 2.
A. I guess I have to figure out the 64 percent number. And that would be a third, 64 percent.
Q. 64 percent.
A. If I'm understanding that -- um, even looking at diclofenac -- let's start at the top of the table -- "all patients .76" -- or even look at the combined. If you combined -- let's make a ballpark guess -- .27 and .46, it's about .4, .5. It's

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somewhere around 50 percent in the all patients.
Q. But remember, this sentence is talking about non-aspirin users.
A. Yes. That's all patients.
Q. Yes.
A. Okay.
Q. No. No. No. I'm sorry.
A. Because, below it, it says "not taking aspirin"; so, up on top you're looking at .76, and it doesn't show me the combined data, but it must be about .4, .5.
It's somewhere around half at the six months.
If I look --
Q. Okay.
A. If I look at the bottom, it's .7 versus .93.
So, from that sentence, it must be the six-month data, not the 12-month data I think that they're talking about.
Q. But in the 12-month data, if you look down at table 2, the far right-hand column, the cell that is on the lower-right-hand corner, it compares both

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NSAIDs for 12 months in non-aspirin users.
It's point -- the P value is .185; correct?
A. But you can't compare percentage based on P value. You'd have to do it on the actual number.
Q. But that is not -- that's not the question I'm asking.
That column shows that at the 12-month data, there was no statistically significant difference between the NSAIDs and Celebrex for the primary end-point of CSUGIEs?
A. Well, you've got me confused, because you asked me about my comments about this sentence that said in 64 percent of fewer side effects on non-aspirin.
Do you want to ask me something else? So, I was calculating that.
Q. And you agreed with me that, or you pointed out that this must refer to the six-month data?
A. I think that must be true.
Q. Because at the 12-month point there was no statistical significance?

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A. It wasn't talking about statistical significance, it was talking about percentage of events in that sentence that said 64 percent.
Q. If you'll go back and look at the sentence, Doctor, at the very end of the sentence it says "a statistically significant difference."
Do you see that?
A. Okay. But then I can't equate that to the 64 percent difference; that's a different question.
If you're asking me about significance, it's obviously correct, but you don't get 64 percent by calculating off P values.
Q. Right. And I understand that. So, put the 64 percent out of your mind.
That sentence, at the end, it says "a statistically significant difference."
If you compare NSAIDs and Celebrex, taking out aspirin users, at six months there was a statistically significant difference; correct?
A. Correct.

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Q. At 12 months there was not a statistically significant difference?
A. Correct.
Q. Would you reword that sentence in any way?
A. Well, I don't prepare documents like this. If I were doing a scientific description, I would talk about the specifics, just that they were listed in the table. So, I would do a more technical analysis about what this was about. So, it's imprecise for me.
Q. Would you explain the difference between the six- and the 12-month data in this document?
A. I would explain a lot of things.
I would have explained the, with and without aspirin.
Q. Would you have explained the reason for the focus on the six-month data in this press release?
A. I think I believed then, as I do now, that after those events accrued, the design of the trial of the subsequent six months are flawed by the overactive dropout

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rate in the diclofenac.
So, the rigor of the design really falls off, so that the fundamental data, as you see in the six months, was the most accurate way to look at the data.
And what troubles me, actually, in your favorite tables is the end on all of these tables reflects the original number, not the dropout rate number.
So, the end is very different between six and 12 months, because of the dropout rate.
So, the relevant scientific place to compare it, for me, was the six-month place.
Q. You would have explained all of that to make that more clear in this press release?
A. I would have explained the dropout rate. I would have explained a lot more.
But I don't -- but I think it would bore people in a press release.
Q. Do you think it would bore people in a journal article?
A. No.

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Q. It would be appropriate, then --
A. Again, it depends on the journal.
Q. It would be appropriate, then, in a journal article to include the discussion that you were talking about there?
A. I would think so.
Q. I'd like to show you -- gosh, Mr. Hoff is going to have a problem there.
MR. HOFF: I've just given up on you.
MR. OLIVER: Off the record.
(Discussion off the record.)
(Needleman Exhibit 240, documents Bates Nos. 9404 to 12, marked for identification as of this date.)
Q. Let me know that you have reviewed it.
A. Okay.
Q. Is this a draft of the press materials that we just looked at, dated April 7th, 2000?
A. It looks like it.
Wait a minute.
I threw it in this never-ending pile.

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It says "draft," and it looks similar to it; so, that would be fine.
Q. Are you copied on the e-mail?
A. Yes.
Q. If you were copied on an e-mail like this, would you have reviewed it?
A. I might have scanned it, and not been too interested in it.
Q. Is this press release different than the final one that we looked at?
A. I guess I better look at it again.
Q. Yes, take some time to compare them.
A. Let me see where I threw it.
I guess I have to throw away things in order, if we're going to go back.
This is new findings; so, it's a different title.
But it has, it looks like it has some of the same language. So, I think there's definitely a relationship between these two documents.
Q. Safe to say that this was an earlier draft of the one that finally went out?

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A. It looks that way, yes.
Q. Can you tell me if those two sentences we just discussed are in this draft?
A. Would you point me to them again.
Q. Go back to the exhibit we were looking at.
A. The 67?
Q. That's right. If you look at the second page, third paragraph. Starting with "the study funded by Searle and Pfizer."
A. Okay. You want me to find that in this?
Q. Yes.
A. It has differences. Okay.
So, it's not the same, but it's got some relationship to the other. What's the question?
Q. You would agree with me, that those exact two sentences that we read are not in this draft, this April 7th draft?
A. Which two sentences?
Q. The two sentences on page 2 of the final, third paragraph, page 2.
A. Which sentence?

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Q. Beginning with "the study funded by Searle and Pfizer."
A. What I see is, instead of saying 64 percent, they've broken it apart. They come up with a 50 percent and a 70 percent.
Q. Where are you --
A. And I see -- I'm reading the one that -- the earlier one, "the study."
Q. Where?
A. You said, "the study funded by."
Q. Right.
A. And so, they've, in this earlier version, they broke up some of the data, and also in this earlier version, they explained -- remember, we found the 50 percent number.
They explained they're also figuring in things that weren't in that table, like the dyspepsia, the pain, and the nausea.
And here -- they're just saying complications -- well, down here they say, dyspepsia, nausea, and they broke it up in a different way, but it looks like it's just differentially, it's not so remarkably different. You see that last sentence.

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That's where they capture the dyspepsia.
So, ask me a question again.
Q. It doesn't have those exact same sentences that were in the final press release -- more specifically, it doesn't say, a statistically significant difference; does it?
A. No, it doesn't.
Oh, wait, wait.
"Current at a significantly higher rate" is the last part of that earlier paragraph.
A scientist or a clinician would say significant means P .05.
So, that's -- so, when you say "significantly higher rate," that would have buried, for me, would be buried in that statement.
Q. For you as an expert in this field?
A. No. As a scientist or a clinician, also.
Q. So, every time they say "significantly," you're telling me they mean statistically significantly?
A. That's what it means to me.

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Q. And it means that to you because of your experience as a clinician or researcher?
A. Maybe so.
Q. Let's look at Exhibit 241.
(Needleman Exhibit 241, documents Bates Nos. 62 to 75, marked for identification as of this date.)
Q. Doctor, take a moment when he gives that to you, and let me know when you've had a chance to look at it.
(Pause.)
Q. Doctor, I can actually help you out. If you'll look at the second, third, there's a part that says "fact sheet."
I'm not going to ask you questions about that. You can skip past that to the draft press release, which starts on about the sixth page. I'm just going to ask you about the e-mail and the draft press release, not the fact sheet.
A. Okay. I'm at the beginning of what looks like the draft on April 11th of what looks like a press release.
Q. Right. You're copied at the top of the e-mail. I'm sorry, the second e-mail,

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the April 11th, two --
A. If you want me to go back to the front page.
Q. Yes. You're copied on that e-mail; correct?
A. Let me take a look. There are a million names here. Yes, I am.
Q. Okay. So, you received a draft of the press release on April 7th; is that correct? That was the previous one.
A. We saw a previous e-mail, yes.
Q. And you received another draft on April 11th?
A. It looks correct, yes.
Q. Did you review this draft, the April 11th draft?
A. I don't know. I might have scanned it. I don't remember. It's not high on my list.
(Needleman Exhibit 242, documents Bates Nos. 5807 to 26, marked for identification as of this date.)
Q. The same as the last time, I'm not going to ask you about the fact sheet, just the press releases. So, you can skip the

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fact sheet.
A. Okay.
Q. This is a third draft of the press release, circulated on April 14th; is that correct?
A. That's what it looks like, yes.
Q. You received a copy of it?
A. I think I'm on the list. Yes.
Q. The subject of the second e-mail in the chain, actually all the e-mails in the chain, it says "RAC approved CLASS press materials." What is the RAC?
A. I don't know. I don't know what RAC is.
Q. Does it sound like it might be the --
Excuse me. Strike that.
Could it be the regulatory affairs committee?
A. There was no such committee.
Q. There was no regulatory affairs committee?
A. No.
Q. Would you have been on the RAC?
A. It could have been research.

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It could have been Research Advisory Committee, not regulatory. But I'm -- I don't know that abbreviation.
Q. Were you on the research advisory committee?
A. I don't understand what that is.
I'm the head of research.
The people, the people who report to me meet with me regularly. So, I'm not sure what this is.
Who knows, what is it called when everyone reports to me?
Q. Do you know if Mr. Hassan would have gotten of a copy of this draft press release?
A. I do not know.
Q. What about Ms. Cox?
A. I do not know.
Q. Look with me at -- go to the press release, the draft press release in this stack, right.
And go to the second page.
And the third paragraph.
A. Yes.
Q. Those are the same sentences that

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ultimately we talked about, and that ultimately made it into the final press release?
A. Question?
Q. Are they?
A. I don't know what the final press release looks like.
Q. That's the one that we looked at, the first press release.
A. Oh, that was it?
Q. That was it. Yes.
A. It looks like it ends with "at a significantly lower rate," and I think we saw that before. It looked like "at a significantly" -- so, I don't know if that's exactly the same.
It looks pretty close. Yes, it looks pretty close.
Q. These are the sentences where you said you would have reworded or modified?
A. No. Where I would have reworded it was that business about "or" instead of "and"; so, I would have clarified it as combined NSAIDs.
Q. Look at that sentence again with

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me, Doctor. Its the press release, second page, third paragraph, "the study" -- the same sentence that you would have reworded, but I want to focus on a different part of it.
MR. HOFF: Are you looking at the final, or the --
Q. I am looking at the one that he has in his hand. It's the April 14, 2000. It's not materially different from the final.
MR. HOFF: I just want to make sure we know what we're looking at.
Go ahead.
Q. Never mind, Doctor, scratch that.
We're done with that one for the moment.
At what point would the company have submitted this CLASS data to FDA?
A. When it was all assembled.
So, you know, you go through all the data, and then there's all the write-ups, there's all the proofing. So, just when it's all done.
Q. Am I correct that the point of that exercise would be to get the label changed?

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A. That's right.
Q. You would have been involved in the discussions after --
Excuse me, strike that.
After the company submitted all of the data to the FDA, there would have been preparation to make a presentation to the FDA about the data?
A. Yes.
Q. How long did that gap last in this case? How long was it before the FDA held the arthritis committee meeting?
A. From what, when they received it?
Q. From May 25th, 2000.
A. Oh, I don't know.
Q. Was it a long time, a year?
A. Um, I don't know. It's not -- I guess, let's backtrack.
Do we know the date of the advisory committee meeting?
Q. It was February 7th, 2001, I think.
A. So, somewhere between May and February; so, that's the kind of time.
Our preparations for the advisory committee would go on maybe a month, or so,

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before the advisory committee.
Q. Is that something you would discuss with Mr. Hassan?
A. No. I mean, he would have known -- it's a -- it's appropriate that he would have known that there is an advisory committee.
And the other thing that's interesting is, I believe that we submitted before Merck, but the FDA decided, instead of doing separate advisory committees, that they would do both Vioxx and Celebrex at the same advisory committee. That would have been pertinent.
And also, by then, I think we would have known about the strokes and the myocardial infarctions that were seen with Vioxx, which would have influenced our preparation for the meeting.
He would have known, at that level, not at documents or --
MR. OLIVER: This is 243.
(Needleman Exhibit 243, document Bates No. 358, marked for identification as of this date.)
A. I have looked at the document.

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I must say I don't know what a lot of the abbreviations are.
Q. Well, that's great, because that's what I was going to ask you about.
A. Yes. Could you tell me what CAIP is?
Q. Can you tell me what the "impact notes cellecoxib registration task force" is?
A. No, I can't.
Q. You would agree with me that, down at the bottom, it says "revised CLASS time lines," you would agree with me that this looks like a schedule for when the report is going to be circulated to different groups of people?
A. It looks like that to me, too.
Q. If you look under "final report," it has your name. So, is it fair to say that at least by May, excuse me, May 10th, 2000, you had received a draft of the report?
A. That's what they hoped, whoever wrote this on April the 20th.
Q. Do you know what ESS stands for, right under that?
A. No, I don't.

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Q. Do you know if Mr. Hassan or Ms. Cox would have received this report?
A. It doesn't look like they're on the list; does it?
Q. But that wasn't my question.
A. Well, that's all I would know who would get it would be the people on this list.
Q. You don't have any idea, based on your experience, whether they would take a look to this before it was submitted to the FDA?
A. I would think this is way below the level of their screen.
Q. You reported directly to them; right?
A. No. I reported to Fred Hassan.
Q. That's who I asked you about.
A. No. You said "them." I didn't report to Carrie Cox.
Q. You reported to Mr. Hassan, you were right under Mr. Hassan?
A. That's correct.
Q. So, this was important enough to go to you, but not Mr. Hassan?

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A. That's correct.
Q. Why is that?
A. Because I'm running R&D and he's running the global business.
MR. OLIVER: This is Exhibit 94.
A. You know that Jim Lefkowith died; I guess you know that?
Q. Sorry to hear that.
A. It's always strange to see his name on these things.
Q. Tell me when you're ready.
(Pause.)
A. Okay, I've read the abstract.
Q. Is this a draft of the JAMA article that was ultimately submitted in June of 2000 for publication regarding CLASS?
A. I think it must be because I see Silverstein is the first author; so, I think it must be.
Q. You received a copy of this?
A. Yes. I probably, yes -- I did receive a copy of the draft.
Q. Do you recall reviewing it?
A. I reviewed -- yes, I would review it.

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Q. Did the JAMA article focus on the six-month data or the 12-month data?
A. I think it focused on the six-month data.
Q. Was there an explanation in the JAMA article of why it focused on the six-month data?
A. Um, I don't remember it then.
Q. Would -- would it have been appropriate to do that, to have an explanation of that?
A. I believe that the six-month data is really representative of the real data.
Q. But that's not my question.
Would it have been appropriate to include in the article an explanation of the difference between the 12-month data and the six-month data?
A. If you ask me, knowing what I know now, it would have been better, but it wouldn't have changed the fundamental conclusions of the data.
Q. Were you aware that Fred Silverstein had asked George Geis to include such an explanation in the JAMA article?

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A. No, I was not.
Q. Would that surprise you?
A. Um, by hindsight or foresight?
Q. Either one.
A. Um, if he went through the analysis that showed the differential dropout rate for diclofenac, and the aspirin confounding data, I would have been interested in why he still wanted to know.
So -- so, the simple answer is, I don't know, I didn't know that he asked for the 12-month data.
Q. You never had a discussion with Dr. Geis about that?
A. While I don't know the time, because questions started to be raised by 12-month data, I was aware that there was going to be a quick follow-up paper, with Lee Simon as the lead author, that would have then handled the 12-month data, showing the context of its relationship.
And so, I thought that they were right on top of each other. But I don't know specific times of the events.
Q. Did Dr. Geis ever say to you, Phil,

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Fred Silverstein wants an explanation of the difference between the six-month data and the 12-month data in the JAMA article?
A. I don't recall that ever.
Q. Is it possible that you just forgot?
A. I don't know if he would have called me Phil.
Q. What would he have called you?
A. Hey you.
Q. Is it possible that you just forgot the conversation because he said hey you?
A. I think it's an important question.
I think Fred Silverstein is an important person, who I respect. He respected us. And I would have wanted a full dialogue.
I'm only surprised that if he did or didn't have a full dialogue. There was really a lot of involvement of those key opinion-layers in the analysis of the data.
I even believe, you'll correct me if I'm wrong, that when issues were raised later in some journals, that he was part of the response group of the external key

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opinionators that explained why the six-month data was used.
So, the question seems odd to me.
Q. Do you understand why people raise concerns about the data that was in the JAMA article?
A. Um, I became aware of that there would be a suspicion that there was something being hidden, and that they didn't know the reasons about the exclusion rate or the aspirin rate.
So, with a, you know, 50/50 hindsight, I would like to have explained, so they saw and knew what we knew. So, yes, that was raised.
Again, if you want context, the main issue is all of the data goes to the FDA, and I'm expecting an FDA advisory committee, just on CLASS, right away.
The FDA delays and waits for Vioxx.
So, I thought the world would know what we know about the 12-month and the six-month data.
Q. As it turns out, the world did not know?

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A. No.
Q. -- for quite some time.
A. Because the CLASS data, the -- the FDA review was pushed off waiting for Merck.
However, I believe that there was an eminent additional journal, article then that was supposed to come by Lee Simon that would present it all.
Q. Did that ultimately happen?
A. It got put off by Lee for a long time. I don't think it appeared for years.
But remember, he's external to Searle, and he's the one who's writing the paper.
We supply the data.
We'll supply our opinions.
But there's no leverage that you can force an independent person to write a paper.
I wish he wrote it the same day.
Q. Would you have discussed this JAMA article with Mr. Hassan?
A. No. I don't think so.
Q. Do you think he would have reviewed it on his own?

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A. Oh, no.
Q. Why do you say that?
A. Um, I actually don't know that he reads JAMA or New England Journal or any other.
Q. Would it be unreasonable for the CEO of a pharmaceutical company to read a JAMA article about one of his key products?
A. If he already knows we've missed the primary end point. We think that's a scientific case.
To do the harder lifting, which is convince the FDA that we should get the label, I wouldn't think the JAMA article is too interesting.
Q. Was the JAMA article relevant to the advisory committee meeting?
A. No.
Q. Why do you say that?
A. Because they have every bit of data. They have the six-month data, they have the 12-month data. They have everything. You can't do even an animal experiment without giving the FDA all the data.

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Q. Would the data that you had given the FDA, the full 12-month data, have been relevant to the clinical community?
A. A journal article is different than an FDA submission.
The FDA has thousands, if not millions, of more data points to consider, and they wouldn't take a subset just based on the journal article.
Q. That wasn't my question. You had said the JAMA article would not be relevant to the advisory committee because they've already got all of that; correct?
A. The FDA, you said?
Q. Yes.
A. Correct.
Q. The public, on the other hand, did not have all that information; correct?
MR. HOFF: Objection to the form.
A. The JAMA article is different from the FDA. The people who read JAMA saw the data that was relevant to the submission of that paper to make its main point.
Q. They didn't see the 12-month data that was submitted to the FDA?

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A. They didn't see 99 percent of the data.
Q. This was data that the FDA thought was very, very significant to make a labeling decision?
MR. HOFF: Objection to the form.
A. Actually, as you recall, the final FDA data was not based on the 12-month data.
Q. That wasn't my question.
A. No. No. I'm saying what is relevant to the FDA? They see it all.
And they pick what's important.
Q. Some --
A. And they did not pick the 12-month data.
Q. They picked something more than six months, though; correct?
A. They picked a nine-month figure.
Q. So, the FDA determined that, for labeling purposes, something greater than six months of data was relevant?
A. The FDA, um, didn't agree about allowing the dropout rate from diclofenac to be adequate to change the label. That's a scientific argument. They make a choice for

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a different criteria.
So, they incorporated all of the data in the nine-month data.
And by the way, as you know, they took some of the arguments we presented and put it in the label.
MR. OLIVER: I move to strike that last sentence as non-responsive.
Q. This is going to be 244.
(Needleman Exhibit 244, documents Bates Nos. 1491 to 1516, marked for identification as of this date.)
Q. Tell me when you've had a chance to look at it.
(Pause.)
A. I have a bunch of "black" pages on mine.
Q. Probably the same ones that I have that have been redacted. Yes.
A. Okay.
Q. The Bear, Stearns healthcare conference, does that mean anything to you?
A. I think this was a California conference that we were invited, the heads of R&D were invited to present.

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It's an analyst and pharmaceutical R&D presentation.
Q. Was it an annual thing?
A. I don't think I went every year. I think it was a specific invitation.
Q. Does it, looking at the front of this, this appears to be something you presented at the healthcare conference; is that correct?
A. Yes, it does.
Q. Do you remember making this presentation?
A. I remember making the presentation.
Q. It was after the class data had been sent to the FDA; correct?
A. Um, you have to help me with the dates.
Q. Do you remember when we -- the final report went to FDA on May 25th.
A. So, yes.
Q. It was after the JAMA article was published?
A. Yes, I think so.
Q. But before the FDA had released all of the full data?

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A. Yes. Before the FDA review, which I think was much later.
Q. This conference was about, it was about investments, it wasn't about healthcare?
A. It was about investors and pharmaceutical companies.
Q. But it wasn't a clinical thing?
A. No.
Q. It was geared towards investment.
Look with me at slide, page 5.
A. Yes.
Q. That second bullet point, is it fair to say you were pumping up the JAMA article to investors?
A. I think, in fact, that made this setting that I presented the JAMA data in this talk.
Q. So, you only presented the six-month data to investors?
A. I think that probably is right.
Q. Look at slide 9, page 9.
There's a slide that says, "The most successful launch in history," and below the slide there are some notes. Are those

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your notes?
A. Actually, I don't think so.
This might have been suggested notes. I mean, I don't have arguments about this, but I wouldn't -- and I always choose to say what I want about the slides; so, the slides would be what I presented.
I wouldn't talk about managed care formularies, or anything like that.
Q. Would you have said that you were confident the FDA would find the CLASS data compelling?
A. Yes.
Q. Did they ultimately find it compelling?
A. Enough to put some of it into the label.
Q. But not enough to do what Searle wanted, or Pharmacia wanted?
A. They didn't give us, they didn't overcome the primary, but they put a number of important things into the label.
Q. Did they remove the NSAID class GI warning?
A. No. But they included the aspirin

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data.
Q. Look with me at slide 11.
A. Okay.
Q. That's the six-month data; isn't that correct?
A. Yes.
Q. Did you explain, at this conference, the difference between the six-month and the 12-month data?
A. No.
Q. Why not?
A. I would have had to give a long explanation of the withdrawal rates, the aspirin rate, and something else that became clear: the dose of diclofenac was too low.
So, this is really functionally giving the data of the JAMA article.
Q. What would the appropriate forum -- what --
Excuse me, strike that.
What forum would have been the appropriate place to explain the six-month data versus the 12-month data?
A. Um, a major publication in a major journal.

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Q. Isn't JAMA a major publication and a major journal?
A. So few people go to a meeting, so that I viewed, knowing what we know, getting the 12-month into JAMA, or someplace else, compared to the six, showing the relevance of the six, and then actually zeroing in on the importance of the hemoglobin hematocrit, the best place for that would be a leading, rigorously reviewed journal.
Q. Is JAMA a leading and rigorously reviewed journal?
A. It's a good journal.
Q. That's a Yes?
A. Yes.
MR. OLIVER: This is 245.
(Needleman Exhibit 245, documents Bates Nos. 6061 to 65 , marked for identification as of this date.)
(Pause.)
A. Okay.
Q. Tell me what this e-mail is about.
A. Um, I think somewhere along the way there's a letter to the editor, and the bulk of this is Jim Lefkowith's point-by-point

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response to the letter to the editor. Ah --
Q. This was --
I'm sorry.
A. And I don't know if both the letter and the response, sometimes they appear in the same journal.
Q. This was after the FDA had released all of the information about CLASS?
A. I think so, because it said somewhere in here -- the comments by one of the letter writers didn't reflect the FDA's review of the CLASS and the advisory committee.
Q. If you look at the second page -- well, you were closely following this discussion?
A. I remember it.
Q. Is this something that you would have discussed with Fred Hassan?
A. I don't remember that discussion at all.
Q. That wasn't my question.
Is this something you would have likely discussed with him?
A. Um --

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MR. HOFF: Excuse me.
A. Probably not.
MR. OLIVER: A little different question.
A. Probably not. This is already after the FDA review.
So, that's not germane to the key issues. What's germane was is FDA agreeing with our scientific argument or not. Will they change the label? He would have been more interested in that than letters to the editor.
The answer is No.
Q. Wasn't this a significant public policy issue for the company?
MR. HOFF: Objection to the form.
A. No. It's not anywhere near as important as the FDA decisions.
Q. Look at the second page of the exhibit, it's the first full paragraph, starting with "accordingly."
A. Yes.
Q. And then, go down to the next to the last sentence in that paragraph that begins "This conclusion."

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"This conclusion is true for both the six-month analysis and the entire study analysis."
A. I'll have to go up and see what the antecedent for this is.
Q. Sure.
(Pause.)
Q. Tell me when you're finished reading.
A. Okay.
Q. That sentence clearly makes a distinction between the six-month analysis and the entire study analysis; correct?
A. No, I think it said -- just the opposite; doesn't it? Doesn't it say the conclusion is true for both the six-month and the entire study analysis? It says that --
Q. Yes. I'm saying --
A. It says to me it's the same.
Q. I'm not talking about the data. I'm not talking about this conclusion.
I'm talking about the sentence makes a distinction between six months and the entire study.
A. It does not. It does just the

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opposite.
Q. According to this sentence, there are six months of data, and then there's an entire study.
A. May I read the sentence to you again?
Q. Sure.
A. "This conclusion is true both for the six-month and the entire study analysis."
Q. What I'm asking you --
A. No distinction between six and 12.
Q. I'm not asking if there's a distinction in the conclusion. I'm not asking you if there's a difference between the six-month data and the entire study analysis substantively. I'm asking you if those are two different groups of data, six-month and the entire study analysis.
A. This conclusion is true for both. So, even if there are two bodies of data, it clearly shows that the 12 agrees with the six. And the six is relevant to publish.
Q. But you agree with me that there's a 12 and a six, and the 12, at least according to this letter, constitutes the

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entire study analysis?
A. I agree that there's no difference between the conclusion between the six and the 12.
Q. But do you agree with me that, when you read this letter, and it says "entire study analysis," it's referring to 12 months of data?
A. Do you want to ask the question again? You asked me about the sentence.
Q. And I just --
MR. OLIVER: Can you read the question back.
(Record read.)
A. I think the entire study is 12 months. I think this sentence says the six and 12 are the same.
Q. So, the entire study is 12 months?
A. Sure -- well, it actually isn't 12 months. It's really cut off at an end point, and only a small fraction of the entire population got the 12 months.
Q. So, this letter is incorrect?
A. No, it's perfect. This conclusion is true for both the six and the 12-month in

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the entire study.
MR. OLIVER: This will be Exhibit 246.
(Needleman Exhibit 246, documents Bates Nos. 6454 to 57, marked for identification as of this date.)
MR. OLIVER: Do you all mind if we take a short break?
MR. HOFF: All right.
THE VIDEOGRAPHER: Off the record at 2:40.
(Recess.)
THE VIDEOGRAPHER: Stand by. Back on the video record at 2:53.
BY MR. OLIVER:
Q. Doctor, I gave you what I think has now been marked as Exhibit 246.
Would you take a moment and read over it, and tell me when you're ready.
(Pause.)
A. Okay, I've read it.
Q. First of all, just looking at the subject line, this is an e-mail that you received on June 4th, 2002, or you sent on June 4th, 2002. What does the subject line

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mean, BMJ editorial?
A. I think that's the British, the British Medical Journal. So, it -- it was an editorial comment, it looks like, about the CLASS data.
Q. Do you remember that particular editorial?
A. I remember that there was an editorial.
Q. Was it critical of CLASS, or was it positive for CLASS?
A. I think it was, um, critical bringing the issue of 12-month, I think, addressing the 12-month versus six-month issue.
Q. You see, below, that Dr. Geis is making some comments and you are responding to those comments in your e-mail.
You say, it's important to understand the numbers. If most of the events in the second six months were celecoxib Celebrex, it is difficult to rationalize because there were still plenty of NSAID patients left.
And then you go on to say some

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more. What does that sentence mean to you?
A. I was confused at this time about the hazard rate -- that is, the ulcer rate of different drugs.
There are some predictions -- this may be more complex than you want.
But if you graph versus time, the argument is: Do the events of the ulcers go up and flatten out, or do they keep climbing?
And I had to understand why would Celebrex keep climbing and, for example, diclofenac flattened out.
I also had to understand, if that was true, why did the number of the events stop at the end of the trial. So, we had to do the event trial.
And, in fact, with time, they convinced me that the diclofenac dropout rate was taking out the population at risk.
Remember, even in the old mucosa data, the real risk rate is only 1 or 2 percent. Now, that sounds like a -- a small number. Except there are 40,000,000 patients. So, the risk rate is a low number.
And so, in fact, if you pulled out

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the diclofenac responders, then you'd be flat.
So, that was the analysis.
I was thoroughly convinced about the six-month data. That wasn't the issue.
I was trying to understand why it was there.
Now, if the other two dropped out, Celebrex will continue that rate.
So, it never reaches a plateau. So, that's what this argument of the hazard rate is. But buried behind it, for me, much more significantly, and why I believe in the data, was there's really important data about the real problem with diclofenac, even without keeping them on the trial, after the symptomatic ulcer was found.
Q. If you look at the second sentence at the end of the paragraph, you called this "one of those hot seat times"?
A. Yes.
Q. Can you explain what you meant there?
A. I always felt if we were wrong, we would explain it. So, that's a big deal, to

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explain.
And if, in fact, we were not correct, then that would have to be disclosed, and that was also my job.
So, I would have been in the hot seat to explain it.
Q. Were you not correct; is that what happened?
A. No. In fact, it was reviewed by the FDA, and they pored over it, and it was pretty clear, we had a scientific, I think we had a scientific case.
They had a higher regulatory barrier. So, they wouldn't change the label.
They did put into the label the aspirin data, and actually, what I came to believe the most important thing was, the hemoglobin hematocrit.
Q. They didn't put the six-month data there, then, did they, the label?
A. Um, the conclusion was on the nine.
But I think what they said about the hemoglobin hematocrit is the same six-month, is the same, the same as 12-month and, in fact, since the dropout rate of

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diclofenac was so high, that any comment relating to diclofenac and hematocrit and hemoglobin would have had to have been the six-month data.
Q. But they ultimately based the label on nine months of data; isn't that right?
A. But there are different parts of the label.
So, if you then go and look at the hemolysis, hematocrit, that's not saying nine months, or 12 months, or six months, it's saying what's the primary event.
Q. But I'm not talking about that. I'm talking about the GI --
(Interrupted)
A. That's in the label. The label has different parts.
It's efficacy parts and there are side affects and nearby organ systems.
So, there are comments in there about cardiac, cardiovascular, and bleed. That's also in the label.
Q. For GI events they use nine months of data?
A. That's correct.

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Q. What was the real problem with diclofenac?
A. It would be funny for me to lead you to a page and to a graph.
The trial is directed at upper GI, because you can't see the lower GI. You can't do endoscopy.
The marker of the whole intestinal tract is hemoglobin hematocrit.
Because if you bleed, it's bleeding from the whole system. At six months and at 12 months, even diclofenac dropped out, is two to three times higher bleed with hemoglobin and hematocrit.
In fact, the calculation is diclofenac is causing the patients to lose two pints more blood than the celebrex patient. And that's compelling and reflects the whole intestinal tract, not the part you can see with endoscopy or see the perforations.
Q. Why was that important to the CLASS analysis? What's the significance of what you just told me?
A. Because for the first time you had

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an ability to see the whole tract, not just the upper GI.
And Celebrex blew away diclofenac or Ibuprofen, with or without aspirin, on hematocrit hemoglobin.
Q. Why was that important in the choice of six months of data versus 12 months of data?
A. The six-month of data is just as good as the 12-month on hematocrit hemoglobin, and the importance is, up to two pints of blood in a patient.
MR. OLIVER: It's going to be 247.
(Needleman Exhibit 247, documents Bates Nos. 2897 to 2906, marked for identification as of this date.)
Q. Tell me when you've had a chance to review this.
A. Thank you.
(Pause.)
A. Okay. There are a lot of parts, and you can lead me through the wilderness.
Q. I will do my best.
If you turn to page 2, the heading of the document says "CLASS advisory

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committee rehearsal minutes."
A. Yes.
Q. Is this a meeting where you all were preparing for the FDA the presentation to the FDA of the CLASS data?
A. We would have had several rehearsals to get ready.
Q. This is just one of those rehearsals?
A. I think that's right. It looks like it's -- I don't know who did the minutes, some regulatory person or something.
Q. Do you remember this meeting in particular?
A. No. There were several -- several, um, including in Skokie, and then even in Bethesda. Even before we went in, we would have a meeting the day before.
Q. Would Mr. Hassan have been at these meetings?
A. Never.
Q. Would you have discussed these meetings with Mr. Hassan?
A. No. He would have been aware that we are preparing for the FDA advisory

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committee. But no, none of the substance.
Q. Look at your comment -- we're still on the same page -- you say --
A. Page 2.
Q. Yes, page 2. The first comment that you make, it says, "Do we need external experts so that it is not just in our own interest?"
What are you suggesting there?
A. It's very, very hard when you're the accused drug company to say that these facts are right.
If someone out -- who's respected and who has a reputation of being critical says it, it's even better.
Q. You say, "We need to focus on changing the mind-set of the people who read the booklet." What booklet?
A. I would think this is the advanced booklet that you send to the FDA, which then gets published the night before, as does the FDA's own booklet.
The recipient target is both the FDA and the advisory committee. The issue is overcoming, we missed the primary end-point.

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Q. So, you're changing their mind-set from what to what?
A. We would like them to understand that when you prospectively design a trial, you don't anticipate what a trial with 8,000 patients will come up with.
And there are scientific issues that if you knew it, you would have had a different prospective design and gotten the label, just as Vioxx did, that Merck did with Vioxx, exclude the aspirin patients, do one comparative.
So, we thought the data was a basis for the change, and we didn't know it before the trial, we knew it retrospectively.
Q. So, you present 12 months of data to the FDA, and you explain to them why you thought six months was more important?
A. We present everything to the FDA.
They, then, do their analysis, and the committee goes after anything they want.
Q. But to you, and the other folks at Pharmacia, this reason for choosing the six months of data was a significantly important issue?

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A. No, no. You're missing the point.
The only way to change the primary was showing that the dropout rate was due to, in fact, that you couldn't have statistical power in the second six months, because the diclofenac's high risk patients were being excluded. So, that's intimate to the discussion with the FDA.
Q. That part about the dropout rate in the second six months was very, very important?
A. Secondly, aspirin data.
Thirdly, hemoglobin hematocrit.
And we got two and tree into the label.
Q. So, the most important data, from what you've just told me, was the dropout rate data in the second six months?
A. Hemoglobin hematocrit, aspirin, all three. Big three for us. It's the weight of the science argument.
We had never said that we hit the primary. We had to get them to think that knowing what you know now, it would have been better to have a different design.

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Q. So, understanding the importance of the six-month data, from, from your standpoint, it was critical to know about this, the three things you just told me, the dropout rate, the aspirin, and the hematocrit data?
A. In the context that the six-month data is the correct analysis of what you had, and here's how you could improve it to change the label.
Q. So, you agree that those three things you mentioned were critical to understanding the six months of data?
A. In the context that the six-month was the correct interpretation.
Q. Okay.
A. Yes.
Q. So, in order to understand and accept why the six months was the correct interpretation, you had to have this discussion about these three critical things that happened in the second six months of data?
A. That's right.
Only to change the label.

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Now, there were sensitivities about not seeing the 12-month, and I accept that, and that's why I wanted a second publication.
But we were after the label change.
Q. Look back on this document. Go to page 4.
MR. HOFF: What's the Bates number?
A. What's the Bates number.
Q. It's 900. Actually, while you're looking for that, while you get to page 900, I'd like to follow up on something you --
You mentioned that second publication again.
Why did you want a second publication?
A. Because people were -- there was a British medical journal, there were people who thought we were being selective, and didn't realize that we thought that was the best, that was a fair representation of the data.
Q. Now, I thought earlier you said that, even before the JAMA article was published, you thought there would be a follow-up publication.

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A. I don't know when that was.
Um, I don't know when -- there was nervousness about the 12 versus the 6.
Q. And you always thought there was going to be a second publication explaining this?
A. Yes. I thought there was going to be a close-on when I heard the issues.
Q. And, in fact, there never was a second publication?
MR. HOFF: Objection to form.
A. It was out of our control. It was up to Lee Simon, who doesn't work for Searle or Pharmacia. He was a major player.
In fact, such a major player, he eventually went from Harvard to the FDA.
Q. You didn't, Pharmacia and you, you all didn't speak out and say something?
MR. HOFF: Objection to form.
A. What's your question? To Lee Simon?
Q. Mr. Simon didn't do the second publication, and you're saying that he --
A. Dr. Simon said he was going to do it, kept saying that he was going to do it,

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and didn't get it done.
Q. And Pharmacia and -- you guys did not step out and say, hey, we wanted Dr. Simon to do this publication, but since he hasn't done it, we're going to tell you about it?
MR. HOFF: Objection to form.
A. Well, that's silly. I mean, that's not the way publications are done.
And that's not data that's published. You needed, as we identified before, someone who is respected who put it in a respected journal.
Q. So, the first time that that data that we just talked about ended up in the public sphere was after the FDA's arthritis committee meeting?
MR. HOFF: Objection to form.
A. The full data went to the FDA right away.
The FDA then delayed waiting until the Vioxx data was in. But that is correct, that the rest of the data was public from the FDA release.
Q. Look with me at the, back to where

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we were, Bates number 900.
A. Page 2?
Q. Yes, sir.
MR. HOFF: 4.
Q. Yeah, 4. It's the --
MR. HOFF: 4, if you include the cover e-mail.
Q. Ending in 900. It should look like that, with the --
A. Thank you.
Q. With the blackouts.
A. All right. Got it.
Q. There's someone named Finman here. Who is Finman?
A. I don't know. Finman?
MR. HOFF: We're at the top.
Q. There's Lee Simon talking, and then there's Mr. or Mrs. Finman.
A. Could that be a Pfizer person sitting there? I don't know who that is.
Q. Finman asks -- Finman says, "Briefing document does not show a significant difference in endoscopy for diclofenac and celecoxib" -- Celebrex -- "looks like cherry-picking data."

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Do you have any idea what that means?
A. No. Nor do I know who that is.
Q. Was Pharmacia later accused of cherry-picking data?
A. I think the only accusation that came up was the concern about 12 versus six months.
Q. Was that ever characterized as cherry-picking, that you're aware of?
A. I don't know.
Q. Turn the page, if you don't mind.
Down at the bottom of this page you just turned to, you make a comment. You say, "What did we learn? Risk factors. Give the answer from a clinical point, then go into statistical aspects. Answer less from the statistical standpoint."
Why did you suggest answering less from the statistical standpoint?
A. I don't know what that means.
Some of the data you don't need to say P05 when there's a tripling of the difference.
So, if I would get you to look at

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the hematocrit, there's a threefold difference. That would be .0001.
So, you don't have to say it's significant or not. It's compelling and therapeutically important. So, that's what I'm guessing.
Q. Turn one or two pages to Bates number ending with 903. And if you could, read -- starting with your comment that says, "Why did the FDA say there was no difference?"; do you see that?
A. Okay.
Q. Read that paragraph there, that grouping of --
A. "Why did the FDA say there was no difference in diclofenac versus Celebrex. Start off with the answer, then show the data and restate the data. Slide 72 -- "
I don't know what it has --
"Do you have the same slide for all cause" --
Q. You don't have to read it out loud.
A. All right. I don't know.
Q. Just familiarize yourself with that whole paragraph there.

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A. I can't, without seeing slide 72 or 433.
Q. Well, go ahead and read all the comments. I'm actually going to ask you about a comment later on down the page.
A. The next one is, to me, one of the most important pieces of data.
Needleman, surprised that aspirin had an effect on diclofenac. This is great. Stop for a minute. Diclofenac is a COX-1 and COX-2 inhibitor. Celebrex is just COX-2. You add aspirin to Celebrex, you'll get more bleeds, you'll get more hematocrit.
If you add aspirin to either Ibuprofen or diclofenac, you should get no difference, if you had the right dose, because you inhibit COX-1 and COX-2.
The dosage of diclofenac picked for this trial was too low because you had as big a response to aspirin with diclofenac as you did with Celebrex.
That's why the trial failed, because you didn't have enough diclofenac, but it was still enough diclofenac to raise the hemoglobin and hematocrit.

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Q. Well, what you just explained to me, was that in the JAMA article?
A. No. It's not in any article.
I wish that was. That's a pretty compelling -- but it was in the FDA.
And so, in the category "knocks my socks off," two things do: Hematocrit and hemoglobin.
And second is the realization that diclofenac still has no side effects, even though it's not the maximum effective dose for an arthritic.
Q. Look down -- you make another comment. You say, "too much data massaging."
A. Where are we?
Q. Yes. Right down the page there.
A. Oh, yes.
Q. Can you tell me what you meant.
A. All I can guess above it is, Jim showed a slide which showed other variables that could have caused this.
You know, I think with a hematocrit with the symptomatic, that you have enough.
If you start saying let's pull out dyspepsia, heartburn, gas, flatulence,

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abdominal pain, it's a little too much. So, that's my guess of what this is.
Q. Look -- flip the page, if you don't mind. You say, "As designed, we did not meet our primary outcome, and we believe it is inappropriate to ignore the practice of medicine by excluding ASA." ASA is aspirin; correct?
A. Yes.
Q. Why do you make this statement?
A. So, the Vioxx is approved, gets the label, and they excluded aspirin.
We didn't, and we didn't get the label. That's what this says. Our data is the same as Vioxx in the patients without aspirin. So, I think that has to be said.
Q. Don't you rely on statistics excluding aspirin in the JAMA article?
A. We're talking about the label now, and we're talking the FDA, and that wasn't a prospective design.
We took all comers, and instead of 10 percent, we had, I think, 22 percent of the patients on aspirin.
Q. What I want to know is: Why is

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something as significant as this aspirin issue in front of the FDA, but not in the JAMA article?
A. I don't remember about aspirin in the JAMA article. I think there is some -- I think there's aspirin data in there.
Of course, in the JAMA article, we can't talk about the Vioxx data. We haven't seen it. That's to the FDA. We didn't even know what their prospective design was. They'd published nothing, said nothing, until it was the FDA review.
It was already -- the word on the street about the big cardiovascular events might have been out there, but we didn't know about the GI events.
By the time the FDA committee came, it was deaths and myocardial infarction.
If you look at the composition of the advisory committee, they were loaded with people who focus on cardiovascular.
Q. Look at the next comment down by Finman. It says, "Provided justification for the six-month analysis period."
When did you determine to do the

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six-month, before or after the blind was broken?
A. We didn't determine to do six months, we said it would be a minimum of six months, but it's an events trial.
So, that's the minimum, because the FDA would want to know more than just an acute appearance.
Q. You're telling me there was no point in time at which you decided to focus on the six months versus the 12-month data?
A. There was no point in time that we said, all the patients will only be six months. We said that was the minimum.
Q. That's not what I'm asking you.
A. Then ask it again.
Q. Was there a point in time between the end of the trial and the April 14th press release, for example, that you, there was a decision to focus on the six months of data?
A. We can't do that. We have to submit all the data.
When the trial is over, it's all the data. We can't, we can't, we can't eliminate patients, we can't eliminate data,

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we can't change the primary end-point.
Q. To do that would be unethical and misleading?
A. That's right. With the FDA, you can't change it.
Q. Can you do it with the public?
MR. HOFF: Objection to the form.
A. The public is not analyzing the trial. And we never did it. We said, in the design, minimum of six months, and it's an event trial.
Q. What about healthcare analysts?
Can you cut the data off with healthcare analysts?
A. If I were a healthcare analyst, I would be concerned what comes out of the FDA meeting. That's the real market for them.
Q. Wouldn't you pay attention to what the head R&D guy at Pharmacia said?
A. Are we asking about health analysts and what's important to them?
They sit down and say what are the sales next year and the year after, and what's the competitive position.
What a head of R&D says is

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irrelevant compared to what the FDA decides.
Q. Why did you give a presentation at the Bear, Stearns healthcare conference if what you say is irrelevant to healthcare analysts?
A. Because the analysts want to analyze the totality of the Pfizer portfolio.
I presented oncology targets.
I presented antibiotics. I presented many other things. They're trying to guess what are our aggregate sales going to be.
Q. Turn over to the end, Bates label 905. I think it's two pages over. No, it's just one page over.
A. Yes.
Q. If you'll look down about the middle of the page, Lee Simon makes a comment.
He says, "Advisory committee is theater, not science. Remember, the first time you won was based on fear."
What does he mean?
A. Ask Lee Simon. I think that's cute. I have no idea what he meant.

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Q. Do you think presenting to the FDA advisory committee is theater, not science?
A. I think the FDA voted eight to nothing to give us the approval.
I think some years before Pfizer brought an NSAID and they voted eight to nothing against it. I think that they're solid clinicians.
The theater part might be that first there's a public commentary, then the analysts are there.
The analysts sit with their computers, and they hear the FDA, and they buy and sell, and then you present, they buy and sell. But the advisory committee vote is about the data.
Q. I want to go over a couple points, and clarify some things that we talked about earlier.
Am I correct that you said you met with Hassan on a monthly basis?
A. Yes.
Q. These meetings were a part of the process at Pharmacia, and as soon as Searle merged with Pharmacia, they continued?

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A. Well, my meetings with -- you're talking about a different meeting.
My meetings with Fred Hassan, we'd have lunch together, we would put our feet at a table, and talk about what you think is important.
Q. Did any of these meetings ever happen before the merger?
A. No. My meetings with him before the merger would always be with a group, we compared our portfolios, we -- we talked about the totality of our portfolio.
And there would be lots of people there.
Q. Did you ever talk about the CLASS study?
A. I would have talked about everything that is going on.
Let's talk about COX-2 inhibitors.
At that time we thought that COX-2 was a platform. We thought it was not going to be just good on arthritis. We knew already it was going to be good on cancer.
We thought that there was a chance that it would be good in Alzheimer's. We

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thought about a second generation called Valdecoxib, or Bextra.

We thought about an injectable form called Parecoxib. This would be a non-narcotic injectable that didn't inhibit platelets.

So, I would have talked about the whole platform of opportunities with COX-2.

Q. And that would have included the CLASS trial?

A. That's right.

Q. And the prospects for the change in Celebrex's labeling?

A. Um, I have to think about when those discussions were.

He certainly would have heard the generality that we did not hit the primary end-point.

I can say, somewhere along the line, maybe even after the FDA, I might have considered, I would have considered doing a second CLASS trial.

I'm that convinced that the six-month data is correct. And now I would have done it without aspirin and a single

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comparative, and there was no reason to go four times the OA dose, and I would have changed the label. That's what I thought.

Q. Did they do that?

A. No, they didn't do it. We would have had that discussion.

But don't forget the outcome.

Pfizer swoops in, gobbles up Pharmacia, and I don't want to come and live in New York. Why would anybody come to New York if they could stay in St. Louis?

Q. Now, these individual meetings that you had with Mr. Hassan, how soon after the merger did you begin having those meetings?

A. Right away.

Q. Right away, like a week?

A. Oh, I don't know when it was scheduled, but -- and it evolved. Pretty soon it was clear that we liked each other.

He knew I was a pain in the ass, but he knew I was honest and we could discuss anything.

He also taught me things about the pharmaceutical industry in development that were very helpful.

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Q. Such as?

A. Um, you have a new drug, a new target, don't go for the giant use, get the minimum use that proves its efficacy, even if it's a small market.

Then you know the dose, you know the safety, and then you could explode it. It's a very interesting lesson.

Q. So, at one of these individual meetings that you had with Mr. Hassan was when you raised the results of the CLASS study?

A. Sometime or other he knew that we failed the primary. We were working the data.

And as I said to the Bear, Stearns, my belief: Stretch, we may be able to change the FDA.

In fact, in my opinion, when deLap was heading that group of the FDA, he seemed to really understand the implication of the aspirin data, but the leadership of the FDA changed in the arthritis group.

Q. So, you had shared with Mr. Hassan, at some point, the significance of the

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aspirin data?

A. Um, I don't know that I shared that specific. I think I just thought, we have compelling scientific answers and data that could sway, we believed, an advisory committee and the FDA.

Q. You said he understood that data, though. You just said, a moment ago you said he understood the significance of the ASA data.

A. Well, I don't know the specifics of what he understood.

I think he understood that we didn't get the primary, and that we thought we had arguments.

I could have explained the aspirin data. You know, it's not something that registers. I would have been glad if he knew the aspirin data.

Q. So, it's possible that you talked to him about it?

A. It's possible.

Q. Is it possible that you talked to him about the difference between, with the diclofenac dropout rate?

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A. You're getting into too much detail. I doubt that the discussion would have gotten there.
Q. But is it possible?
A. It's possible. You talk to him about it. No, it's possible.
Q. I think I was calling him Ms. Hassan before we got here.
MR. HOFF: Or Mr. Cox.
Q. So, that's a Yes, it is possible?
A. It's possible that you talked to him, yes.
Q. No, it's possible that you talked to him about it?
A. I don't remember.
Q. Did you tell Mr. Hassan that the study became biased after six months?
A. I don't think so. I don't think we had that discussion at all.
Q. Is it possible that you discussed that?
A. It's possible that you did, too.
Q. So, you agree with me, yes?
A. No. I don't think so.
Q. The answer is yes?

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A. I think no. It doesn't sound like I conversation I'd have had with him.
Q. So -- well, was it possible that you had that conversation?
A. I don't think so. I don't recall it.
Q. Searle and Pharmacia merged in April of 2000.
As soon as that merger was done, you would have had one of your, within a month, you would have had your lunch with Mr. Hassan.
A. We evolved a relationship. I don't know if it started immediately, but pretty quickly we had weekly lunches.
Q. You would have talked to him at those initial --
A. In fact, I think it might have taken some time, because I then launched into a review of the entire portfolio of Pharmacia and Searle.
All of the trial, all of the companies, and that review probably took a couple of months.
And then, from that review, we shut

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down some of the development projects, both in Searle and Pharmacia.
So, I would think sometime after that was the evolution. So, my job was to combine the two, to decide what do we want to bet on, and what do we put a bullet in the head into.
Q. Is it possible that you discussed the results of the CLASS trial with him in May of 2000?
A. I don't think I discussed the details of the trial with him.
I would have discussed some of the generalities we talked about.
The key point: We didn't hit the primary; we're going to have an advisory committee; I probably would have added when it became -- that we don't have strokes, or cardiovascular, or congestive heart failure, Vioxx does; and that we could make a rational science argument that might bend them to give us the label.
Q. Could that have happened in May of 2000?
A. I don't know when.

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Q. When you say you would have had a rational science argument that would persuade the FDA, would you have explained that argument to him?
A. I don't think so.
Q. Is it possible that he asked about it?
A. I don't remember.
Q. But it is possible? You don't remember it happening, but is it possible?
MR. HOFF: Objection to form.
A. If possible, I can only answer in the context of my long-term relations and what we covered, and I don't think we would have drilled into those issues. I don't remember them.
Q. You testified earlier that you think that the 12 months study data was very important for the FDA advisory committee.
MR. HOFF: Objection to form.
A. I thought, what I really -- the point I was trying to make is, the FDA analyzes everything.
Q. Why is it important that they get everything?

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A. That's the law. They have to analyze --
And, you know, if you look at the paper, it fills a room like this.
And then they get all these specialists, safety, oncology, teratogeneticists, clinical trials. And they don't want to trust what the drug company says.
They analyze, they go over the data. That's the way I read a paper, I read the data. I don't read the discussion.
So, the reality is that they have to understand the totality of the data because they have a higher standard to approve a drug that's going to reach a lot of people. It's a higher standard than a journal.
Q. They need the entire totality of the data, as you call it, so that they can make an accurate, unbiased determination about the drug?
A. Yes.
Q. Doesn't the public have a right to make the same kind of assessment?

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MR. HOFF: Objection to form.
A. The data in the six-month is an accurate reflection. So, I think that was an accurate reflection of the data.
Q. But it's not the totality of the data.
A. But that's a publication, not a regulatory approval.
Q. So, you agree that you did not give the totality of the data to the public?
A. We did not give them the FDA application as the publication.
Q. FDA ultimately gave that to them on FDA's Website; correct?
A. The night before they released the material. And they don't divide it into 12 and six months, they drew a conclusion.
Q. We've talked about a lot of things, we've talked about the importance of the diclofenac dropout rate, and the aspirin, and the focus on the six months --
A. And the hematocrit hemoglobin.
Q. Right. In order to understand the significance of all of this stuff at the six-month point, isn't it fair to say that

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you had to know what was happening in the second six months, in the 12 months?
MR. HOFF: Objection to form.
A. The dropout rate already shut down the trial.
So, you've got -- you see, you lost statistical power for the second six months. So, you had to emphasize the six-month data.
What's wrong with the tables you showed me is they kept showing 3900 patients. When you're saying the second six months, that was the enrollment numbers.
Show me what the final numbers are on diclofenac, then you begin to understand the impact of it. So, you can't do statistical analysis, because you had too high a loss of the high-risk patient.
Q. So, in order to understand the significance of what you're telling me is you've got to talk about this diclofenac issue and what happened with the dropout rate?
MR. HOFF: Objection to form.
A. The six-month data accurately reflects the outcome of the trial.

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Q. But that's not my question.
My question is: You talked about the importance of this diclofenac dropout rate, and you've explained to me very eloquently why you need to talk about this to understand the significance and importance of the six-month data.
Am I telling you what you -- is that accurate?
A. Of course.
MR. HOFF: Objection to form.
A. We're not talking to each other, we're talking around.
There are two issues.
One, I have to cope with we missed the primary, and always said we did. And we want to change the label.
You know, the second thing on my mind is, we now have learned how to do the trial correctly. That's on my mind.
I have a real conviction that the six-month data information in JAMA reflected the trial and the reality of it -- different than what's in the FDA, but reflected the right data.

You know, eventually the 12-month data did come out. It was later. It didn't change anything.

Q. What do you mean it didn't change anything?

A. Didn't change the world; didn't change the reality of the six-month data; didn't change the marketplace.

MR. OLIVER: If we can take a short break, I'm probably done.

THE VIDEOGRAPHER: Off the video record at 3:44.

(Recess.)

MR. OLIVER: Thank you.

Nothing further.

(Time noted: 3:52 p.m.)

PHILIP NEEDLEMAN

Subscribed and sworn to before me this day of 20___.

C E R T I F I C A T E

STATE OF NEW YORK)

) ss.

COUNTY OF NEW YORK)

I, ROBERT X. SHAW, CSR, a Notary Public within and for the State of New York, do hereby certify:

That PHILIP NEEDLEMAN, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by such witness.

I further certify that I am not related to any of the parties to this action by blood or marriage; and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 20 day of December, 2010.

_____

ROBERT X. SHAW, CSR

---------- I N D E X ----------

DEPOSITION ERRATA SHEET

Our Assignment No.: 315763, File 17433.
Case Caption: Alaska v Pharmacia

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

_____
Philip Needleman

Subscribed and sworn to on the ____ day of _____, 20 ____ before me.

_____
Notary Public,
in and for the State of
_____.

DEPOSITION ERRATA SHEET

Page No.____Line No.____Change to:_____
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SIGNATURE:_____DATE:_____
Philip Needleman

DEPOSITION ERRATA SHEET

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SIGNATURE:_____DATE:_____
Philip Needleman

EXHIBIT 161

alex rolle

From: JORDAN, DAVID C. [PHR/1825]
Sent: Wednesday, April 05, 2000 8:52 AM
To: MAURATH, CLEMENT [PHR/1825]; COUGHLIN, OLIVIA A. [PHR/1825]; BEGLEY, WINIFRED M. [FND/1825]; ZHAO, WILLIAM W [PHR/1825]
Subject: FW: CLASS Trial

Everyone - fyi after the presentation at Peapak Dave

-----Original Message-----
From: FRIEDMAN, MICHAEL A [PHR/1825]
Sent: Wednesday, April 05, 2000 7:54 AM
To: GEIS, GEORGE S. [PHR/1825]; LEFKOWITH, JAMES B. [PHR/1825]; JORDAN, DAVID C. [PHR/1825]
Subject: FW: CLASS Trial

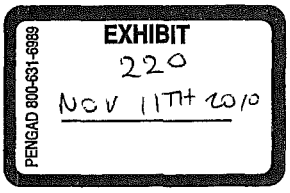
Some suggestions from Goran.
MAF

-----Original Message-----
From: Goran.Ando@pw15mg.kzo.us.pnu.com [mailto:Goran.Ando@pw15mg.kzo.us.pnu.com]
Sent: Wednesday, April 05, 2000 7:29 AM
To: michael.a.friedman@monsanto.com; philip.needleman@monsanto.com
Cc: Susan.Reiner@pw15mg.kzo.us.pnu.com
Subject: CLASS Trial

Phil/Mike,

Some further thoughts on this trial for your info. Please adopt or discard as you see fit; these are sent in a spirit of cooperation and help rather than trying to be critical.

1. Verify that ibuprofen 2400 mg/day is generally accepted as the safest of NSAIDs. Due to poor compliance, my experience has been that many patients actually take less. Also, I suspect many still prescribe 1200-1800 mg for OA. I suspect Merck might attack this point to try to shake the credibility of the CLASS trial outcome. Certainly the ibuprofen dose is an issue in Europe.
2. For the FIRST public disclosure of the data, it might be worthwhile thinking through whether (a) only showing results of NSAIDs combined or (b) only showing results vs. ibuprofen makes sense. I guess the answer is probably no, but it's worth going through the exercise formally.
3. To me, the hematocrit data is by far the most compelling - and interesting. Maybe the storyline in presentation should be to start by showing that followed by PUBs and then POBs rather than the reverse order. Apart from making more of the hematocrit story through use of more slides, it might also be worthwhile trying to show all key results on one summary; as ALL results go in the right direction. Visual impression of that is usually powerful.
4. There is an almost separate message of the overall excellent toleration of Celebrex and that should not be forgotten - although it may need a separate forum to present the full story. The renal, hepatic and CV complications of NSAID are rarely discussed but do exist and are clinically very important.
5. You may also want to "model" what can be expected from Merck in response to the presentation of the CLASS trial. In my book they are desperate and will attack everything. An immediate thought would then be for us to focus on the non-ASA results; this is the comparable group to Merck's own study and thus cannot be attacked. [redacted] Non-Resp.



Non-Resp.

I have not seen much data from Merck's own study and (premature) announcement but I'm sure there is significant knowledge in the company of known and predicted outcome of their study. This will give pointers as to where the attacks will come.

6. The regulatory process to change labeling needs a separate strategy, which will need to be clear by the time of submission. The CLASS study has sufficient novelty in my mind to get FDA actually to sit and listen to a presentation upfront should that be seen as helpful. Maybe worth considering.

I would have thought an advisory committee will be helpful; at least my experience is that it is easier to get the discussion focused on what is clinically relevant; clearly in my mind the findings in CLASS are clinically relevant. This strategy could be high risk as it is not unlikely that FDA will consider both CLASS and Merck's outcome study at the same meeting. Probably still worth it though.

7. Would suggest a Q&A document should be prepared to ensure PR/IR give the same answers as the presenters. Internal communications is probably also a good idea.

Apologies for a rambling email but tried to give you some of my thoughts.
All the best,

Göran

EXHIBIT 162

PHARMACIA CORP /DE/

Reported by

SHAPIRO ROBERT B

FORM 4

(Statement of Changes in Beneficial Ownership)

Filed 03/12/01 for the Period Ending 02/28/01

Address	100 ROUTE 206 NORTH PEAPACK, NJ 07977
Telephone	9089018000
CIK	0000067686
SIC Code	2800 - Chemicals & Allied Products
Industry	Major Drugs
Sector	Healthcare
Fiscal Year	12/31

OMB APPROVAL
OMB Number
Expires:
Estimated average burden
hours per response 0.5

U.S. SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 4

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP

Filed pursuant to Section 16(a) of the Securities Exchange Act of 1934,
Section 17(a) of the Public Utility Holding Company Act of 1935 or
Section 30(f) of the Investment Company Act of 1940

[X] Check box if no longer subject of Section 16. Form 4 or Form 5 obligations may continue. See Instruction 1(b).

1. Name and Address of Reporting Person*

Shapiro	Robert	B.
(Last)	(First)	(Middle)

800 North Lindbergh Blvd.
(Street)

St. Louis	Missouri	63167
(City)	(State)	(Zip)

2. Issuer Name and Ticker or Trading Symbol

Pharmacia Corporation
PHA

3. IRS Identification Number of Reporting Person, if an Entity (Voluntary)

4. Statement for Month/Year

February 2001

5. If Amendment, Date of Original (Month/Year)

6. Relationship of Reporting Person to Issuer
(Check all applicable)

[X] Director * [_] 10% Owner
[_] Officer (give title below) [_] Other (specify below)

* Retired on February 21, 2001

7. Individual or Joint/Group Filing (Check applicable line)

[X] Form filed by one Reporting Person
[_] Form filed by more than one Reporting Person

Table I -- Non-Derivative Securities Acquired, Disposed of, or Beneficially Owned

1. Title of Security (Instr. 3)	2. Transaction Date (mm/dd/yy)	3. Transaction Code (instr. 8) Code	V	4. Securities Acquired (A) or Disposed of (D) (Instr. 3, 4 and 5) Amount	(A) or (D)	Price	5. Amount of Securities Beneficially Owned at End of Month (instr. 3 and 4)	6. Owner-ship Form: Direct (D) or Indirect (I) (Instr.4)	7. Nature of Indirect Beneficial Ownership (Instr. 4)
Common Stock	2/15/01	M		215,000	A	$27.64			
Common Stock	2/15/01	S		251,500	D	$51.498			
Common Stock	2/15/01	F		32,196	D	$51.70	31,894(1)	D	

* If the Form is filed by more than one Reporting Person, see Instruction 4(b)(v).

Reminder: Report on a separate line for each class of securities beneficially owned directly or indirectly.

(Print or Type Responses)

(Over)

(Form 4-07/98)

FORM 4 (continued)

Table II -- Derivative Securities Acquired, Disposed of, or Beneficially Owned

(e.g., puts, calls, warrants, options, convertible securities)

1. Title of Derivative Security (Instr. 3)	2. Conversion or Exercise Price of Derivative Security	3. Transaction Date (Month/Day/Year)	4. Transaction Code (Instr. 8)	5. Number of Derivative Securities Acquired (A) or Disposed of (D) (Instr. 3, 4 and 5)		6. Date Exercisable and Expiration Date (Month/Day/Year)		7. Title and Amount of Underlying Securities (Instr. 3 and 4)		8. Price of Derivative Security (Instr. 5)	9. Number of Derivative Securities Beneficially Owned at End of Month (Instr. 4)	10. Ownership Form of Derivative Security: Direct (D) or Indirect (I) (Instr. 4)	11. Nature of Indirect Beneficial Ownership (Instr. 4)
			Code V	(A)	(D)	Date Exercisable	Expiration Date	Title	Amount or Number of Shares				
Option (right to buy)	$27.64	2/15/01	M		215,000 (2)		4/25/06	Common Stock	215,000		1,791,276	D	

Explanation of Responses:
(1) Includes 3,046 shares acquired through Pharmacia Corporation's Dividend Reinvestment Plan.
(2) On or prior to March 31, 2000

/s/ Don M. Schmitz — *3/12/01*

**Signature of Reporting Person — Date

*Don M. Schmitz, attorney-in-fact for Robert B. Shapiro

* Executed pursuant to a Power of Attorney ** Intentional misstatements or omissions of facts constitute Federal Criminal Violations.

See 18 U.S.C. 1001 and 15 U.S.C. 78ff(a).

Note: File three copies of this Form, one of which must be manually signed.
If space provided is insufficient, see Instruction 6 for procedure.

End of Filing

PHARMACIA CORP /DE/

Reported by

SHAPIRO ROBERT B

FORM 4

(Statement of Changes in Beneficial Ownership)

Filed 09/11/00 for the Period Ending 08/31/00

Address	100 ROUTE 206 NORTH PEAPACK, NJ 07977
Telephone	9089018000
CIK	0000067686
SIC Code	2800 - Chemicals & Allied Products
Industry	Major Drugs
Sector	Healthcare
Fiscal Year	12/31

OMB APPROVAL
OMB Number
Expires:
Estimated average burden
hours per response 0.5

U.S. SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 4

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP

Filed pursuant to Section 16(a) of the Securities Exchange Act of 1934,
Section 17(a) of the Public Utility Holding Company Act of 1935 or
Section 30(f) of the Investment Company Act of 1940

[_] Check box if no longer subject of Section 16. Form 4 or Form 5 obligations may continue. See Instruction 1(b).

1. Name and Address of Reporting Person*

Shapiro	Robert	B.
(Last)	(First)	(Middle)

800 North Lindbergh Blvd.
(Street)

St. Louis	Missouri	63167
(City)	(State)	(Zip)

2. Issuer Name and Ticker or Trading Symbol

Pharmacia Corporation
PHA

3. IRS Identification Number of Reporting Person, if an Entity (Voluntary)

4. Statement for Month/Year

August 2000

5. If Amendment, Date of Original (Month/Year)

6. Relationship of Reporting Person to Issuer
(Check all applicable)

[X] Director [_] 10% Owner
[_] Officer (give title below) [_] Other (specify below)

Chairman of the Board

7. Individual or Joint/Group Filing (Check applicable line)

[X] Form filed by one Reporting Person
[_] Form filed by more than one Reporting Person

Table I -- Non-Derivative Securities Acquired, Disposed of, or Beneficially Owned

1. Title of Security (Instr. 3)	2. Transaction Date (mm/dd/yy)	3. Transaction Code (Instr. 8) Code	V	4. Securities Acquired (A) or Disposed of (D) (Instr. 3, 4 and 5) Amount	(A) or (D)	Price	5. Amount of Securities Beneficially Owned at End of Month (Instr. 3 and 4)	6. Ownership Form: Direct (D) or Indirect (I) (Instr.4)	7. Nature of Indirect Beneficial Ownership (Instr. 4)
Common Stock	8/9/00	S		86,770	D	$58.08			
Common Stock	8/22/00	M		670,000	A	$27.64			
Common Stock	8/23/00	S		87,241	D	$56.54			
Common Stock	8/23/00	S		633,500	D	$56.71	100,571(1)	D	

* If the Form is filed by more than one Reporting Person, see Instruction 4(b)(v).

Reminder: Report on a separate line for each class of securities beneficially owned directly or indirectly.

(Print or Type Responses)

(Over)

(Form 4-07/98)

FORM 4 (continued)

Table II -- Derivative Securities Acquired, Disposed of, or Beneficially Owned

(e.g., puts, calls, warrants, options, convertible securities)

1. Title of Derivative Security (Instr. 3)	2. Conversion or Exercise Price of Derivative Security	3. Transaction Date (Month/Day/Year)	4. Transaction Code (Instr. 8)	5. Number of Derivative Securities Acquired (A) or Disposed of (D) (Instr. 3, 4 and 5)		6. Date Exercisable and Expiration Date (Month/Day/Year)		7. Title and Amount of Underlying Securities (Instr. 3 and 4)		8. Price of Derivative Security (Instr. 5)	9. Number of Derivative Securities Beneficially Owned at End of Month (Instr. 4)	10. Ownership Form of Derivative Security: Direct (D) or Indirect (I) (Instr. 4)	11. Nature of Indirect Beneficial Ownership (Instr. 4)
			Code V	(A)	(D)	Date Exercisable	Expiration Date	Title	Amount or Number of Shares				
Option (right to buy)	$27.64	8/22/00	M		670,000 (2)		4/25/06	Common Stock	670,000		2,006,276	D	

Explanation of Responses:
(1) Includes 3,027 shares acquired through Pharmacia Corporation's Dividend Reinvestment Plan.
(2) On or prior to March 31, 2000

/s/ Janet L. Horgan — *9/11/00*

Signature of Reporting Person — *Date*

*Janet L. Horgan, attorney-in-fact for Robert B. Shapiro

* Executed pursuant to a Power of Attorney ** Intentional misstatements or omissions of facts constitute Federal Criminal Violations.

See 18 U.S.C. 1001 and 15 U.S.C. 78ff(a).

Note: File three copies of this Form, one of which must be manually signed.
If space provided is insufficient, see Instruction 6 for procedure.

End of Filing

PHARMACIA CORP /DE/

Reported by

SHAPIRO ROBERT B

FORM 4

(Statement of Changes in Beneficial Ownership)

Filed 08/10/00 for the Period Ending 07/31/00

Address	100 ROUTE 206 NORTH PEAPACK, NJ 07977
Telephone	9089018000
CIK	0000067686
SIC Code	2800 - Chemicals & Allied Products
Industry	Major Drugs
Sector	Healthcare
Fiscal Year	12/31

OMB APPROVAL
OMB Number
Expires:
Estimated average burden
hours per response 0.5

U.S. SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 4

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP

Filed pursuant to Section 16(a) of the Securities Exchange Act of 1934,
Section 17(a) of the Public Utility Holding Company Act of 1935 or
Section 30(f) of the Investment Company Act of 1940

[_] Check box if no longer subject of Section 16. Form 4 or Form 5 obligations may continue. See Instruction 1(b).

1. Name and Address of Reporting Person*

Shapiro	Robert	B.
(Last)	(First)	(Middle)

800 North Lindbergh Blvd.
(Street)

St. Louis	Missouri	63167
(City)	(State)	(Zip)

2. Issuer Name and Ticker or Trading Symbol

Pharmacia Corporation
PHA

3. IRS Identification Number of Reporting Person, if an Entity (Voluntary)

4. Statement for Month/Year

July 2000

5. If Amendment, Date of Original (Month/Year)

6. Relationship of Reporting Person to Issuer
(Check all applicable)

[X] Director [_] 10% Owner
[_] Officer (give title below) [_] Other (specify below)

Chairman of the Board

7. Individual or Joint/Group Filing (Check applicable line)

[X] Form filed by one Reporting Person
[_] Form filed by more than one Reporting Person

Table I -- Non-Derivative Securities Acquired, Disposed of, or Beneficially Owned

1. Title of Security (Instr. 3)	2. Transaction Date (mm/dd/yy)	3. Transaction Code (Instr. 8)		4. Securities Acquired (A) or Disposed of (D) (Instr. 3, 4 and 5)			5. Amount of Securities Beneficially Owned at End of Month (Instr. 3 and 4)	6. Ownership Form: Direct (D) or Indirect (I) (Instr.4)	7. Nature of Indirect Beneficial Ownership (Instr. 4)
		Code	V	Amount	(A) or (D)	Price			
Common Stock	4/12/00	I(1)	V	4,274	D	$54.562			
Common Stock	7/28/00	S		447,600	D	$56.181			
Common Stock	7/31/00	S		352,400	D	$55.4628	238,082(2)	D	

* If the Form is filed by more than one Reporting Person, see Instruction 4(b)(v).

Reminder: Report on a separate line for each class of securities beneficially owned directly or indirectly.

(Print or Type Responses)

(Over)

(Form 4-07/98)

FORM 4 (continued)

Table II -- Derivative Securities Acquired, Disposed of, or Beneficially Owned

(e.g., puts, calls, warrants, options, convertible securities)

1. Title of Derivative Security (Instr. 3)	2. Conversion or Exercise Price of Derivative Security	3. Transaction Date (Month/Day/Year)	4. Transaction Code (Instr. 8)		5. Number of Derivative Securities Acquired (A) or Disposed of (D) (Instr. 3, 4 and 5)		6. Date Exercisable and Expiration Date (Month/Day/Year)		7. Title and Amount of Underlying Securities (Instr. 3 and 4)		8. Price of Derivative Security (Instr. 5)	9. Number of Derivative Securities Beneficially Owned at End of Month (Instr. 4)	10. Ownership Form of Derivative Security: Direct (D) or Indirect (I) (Instr. 4)	11. Nature of Indirect Beneficial Ownership (Instr. 4)
			Code	V	(A)	(D)	Date Exercisable	Expiration Date	Title	Amount or Number of Shares				
Option (right to buy)	$52.8125	6/23/00	M	V	6,600		6/23/00	6/22/10	Common Stock	6,600		2,676,276	D	

Explanation of Responses:
(1) Disposition of shares held indirectly through 401(k) account
(2) Includes 3,027 shares acquired through Pharmacia Corporation's Dividend Reinvestment Plan.

/s/ Janet L. Horgan — *8/9/00*

**Signature of Reporting Person — Date

*Janet L. Horgan, atorney-in-fact for
Robert B. Shapiro

* Executed pursuant to a Power of Attorney

** Intentional misstatements or omissions of facts constitute Federal Criminal Violations.

See 18 U.S.C. 1001 and 15 U.S.C. 78ff(a).

Note: File three copies of this Form, one of which must be manually signed.
If space provided is insufficient, see Instruction 6 for procedure.

EXHIBIT 163

From: Bahrt, Kenneth
Sent: Wednesday, January 10, 2001 6:27 PM
To: Gandelman, Mitchell; Kitsis, Elizabeth
Subject: FW: 1/9 CLASS AC prep rehearsal meeting notes
Mitch and Liz. I think this sums it up pretty well. Ken

-----Original Message-----
From: Weiner, Ethan
Sent: Wednesday, January 10, 2001 1:24 PM
To: Wahba, Mona M; Shafner, Lori S; Cristo, Stephen; Gavigan, Michael; Bahrt, Kenneth; Finman, Jeffrey; Frost, R Wayne ; Lan, Gordon; Dieck, Gretchen
Cc: Loose, Leland D
Subject: RE: 1/9 CLASS AC prep rehearsal meeting notes

It looks as if many of the questions: study design 4; ASA 1,2,3,5; Rash 3,4,5; Renal (all) require new analyses or dredging up old analyses and all are quite answerable so this should not be problematic. Answers to questions such as OA vs RA 3,4; Non-Res Rash 1,2 should have been known at the presentation. This leaves Study design questions 1,2,3,5,6; ASA 4; OA vs RA 1,2 which should have been made very clear by the presentation itself. The fact that these things remain unclear to me indicates that the presentation has to be carefully gone over. Certain things should be openly stated, not "buried" in the presentation, i.e.

- we did not achieve our primary efficacy parameter, but here's why the results are still good
- we did not see any difference between celecoxib and NSAID after 6 months, but here is why and here is why the initial 6 month analysis is the critical one, and so on

The fact that somebody would have to ask what the primary endpoint is, or why things went on beyond six months but only a six month analysis is shown indicates shortcomings with the presentation that need to be fixed. I think those of us familiar with the project would not easily pick up on this since we already know the answers, but clearly the presentation does not make this clear enough to the uninitiated. We'll see how things go next week.
-E

-----Original Message-----
From: Wahba, Mona M
Sent: Wednesday, January 10, 2001 12:35 PM
To: Wahba, Mona M; Shafner, Lori S; Cristo, Stephen; Gavigan, Michael; Bahrt, Kenneth; Finman, Jeffrey; Frost, R Wayne ; Lan, Gordon; Dieck, Gretchen
Cc: Weiner, Ethan; Loose, Leland D
Subject: 1/9 CLASS AC prep rehearsal meeting notes

Dear Team,

Ken, Wayne, Jeff and i from Pfizer attended the subject meeting yesterday.
The panel was chaired by Dr. Michelle Petri, please find attached the names of the consultants who attended the meeting.

The following questions were raised by the panel after reviewing the BD and hearing Jim's presentation (the slides were forwarded to you last week):

Study design:
1. Where is the entire 12 m analysis for the primary and secondary objectives? P values? Did the study meet its primary endpoint?
2. Was the 6 m analysis planned in the protocol?
3. Why did the CLASS committees decide to stop the study early? What were the preplanned criteria for ending the study? Need to be clarified in the presentation.
4. Is there any correlation between GI symptoms and incidence of GI ulcers in pts tx with NSAIDs in general and diclo in specific (epi data) to support the "depletion of susceptible" rationale? Did the McDonalds PUB (BMJ 11/23/87)have a diclo arm to evaluate the constant hazard ratio? did that study had a high drop out for GI symptoms?
5. How can you label CLASS as a long term study if you are showing only 6 m results?
6. What is the definition used for GI ulcers, depth?size? How were they documented films? videotapes?

ASA:
1. Did you analyze the data by ASA dose (81 mg vs 325mg)?
2. Does the NDA data support CLASS outcomes re use of low dose ASA as a con med with Cx?
3. In clinical practice based on the CLASS data, what is the # of pts to treat to prevent one event for pts on Cx and low dose ASA?
4. Are you willing to accept a label change for GI warning for only ASA users?
5. Did you analyze the Hg and Hct changes for ASA vs non ASA users?

OA vs RA:
1. Why did you combine the 2 dz in the study? Did you stratify by dz?
2. How did you define OA?
3. Any difference in GI event incidence by dz?
4. Age difference in OA vs RA pts?

Non-F Non-Resp

PLAINTIFF'S EXHIBIT NO. 131 FOR IDENTIFICATION DATE: 8/18/10 RPTR: TD
PENGAD 800-631-6989

Rash:

1. Why there is a high incidence of rash in CLASS vs the NDA? Any explanations? is it significant enough to add to the label?
2. Did you exclude pts with sulfonamide allergy?
3. Is sulfa allergy relevant in terms of rash?
4. What is the incidence of rash within the first 28 days of tx?
5. What is the mechanism of rash? how does it look like?

Renal:

1. Did pts with edema have inc in Cr?
2. Did pts with edema have HTN?
3. What is the impact of fluid retention on HTN and renal functions? make sure to have into consideration the pt's age, wt and gender not only Cr Cl.
4. What is the time course of renal events? first month?

Non-Resp.

PMS data

2000 data?

Other:

Is endoscopy a surrogate marker for GI events based on CLASS data?

The joint clinical/biometrics team will be working on preparing new analysis and slides to address the above questions.
If you think of any other questions, please forward them to me ASAP.

Jeff, Ken, Wayne,

Please feel free to add any additional comments i might have missed.

Mona M. Wahba, M.D.
Pfizer Global Research and Development
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EXHIBIT 164

CLASS Sr. Management Rehearsal
01-17-01

Spivey: Submitted last year to the FDA, Spivey will change in his opening comments currently stated this year.

*General Slide Comments (Sarah and Paula findings)

1 Rick Spivey's slide should go into Jim's presentation since Jim introduces the consultants.
2 B-deck slide #451- 35 ulcer complication shsould this be 38?
3 Number of renal cases to renal events by treatment group-(Slide needed)
4 Slide #27 started mentioning study numbers
5 Slide #40 anticoagulants were used by a small group and mentioned steroid use was less.
6 Slide #57 talked about relative risks but how many total AE's?
7 Slide #53 said people or NSAIDS are 7 fold more likely to develop complications does not speak to slide
8 Slide #64 p-values are needed
9 Slide #69 change title to be the same as slide #53
10 Slides #71 to #74 drug names need a change for format
11 Slide #89 what is mg%?
12 Slide 101 no ASA data on this slide

Questions and Answers (Possible Slides needed)

1 Slide with dates of DSMB meetings
define that they were blinded throughout study
Define why they unblinded study
2 Other reasons for blood loss
3 How many patients developed liver failure (Possible slide needed)
4 Update slides #476 and #477 to include 2000
5 Endoscopy by treatment group (possible slides)
6 Bone density slide from 024 (Possible slides)
7 B-Deck Slide #99 through #101 into Steve's main presentation
8 Is there any Pharmacoeconomic data?
9 Jim's slide with background rates ARAMIS, MUCOSA, CLASS learnings missing from this presentation.

Geis:
*Slide #4, first bar graph appears more like 17-18%, Geis indicated about 15%
*Slide 23 Missing "Accident" for cerebrovascular

Lefkowith:
Andrew Whelton should be introduced as Andrew, not Andy that is his preference.
Slide 23 need to spell out EC the first time it shows up
Slide 35 Can't read the p value of 0.09
Slide 46, Jim said .8 slide shows .185, Needleman: Last point on the slide should have +/- aspirin

Clarification: none went right into Q/A

Q/A

EXHIBIT 278

Δ π EXHIBIT 278
Deponent STRAND
Date 12/14/10 Rptr. AG
WWW.DEPOBOOK.COM

Spivey: Was there criteria for ulcer depth?
Lefkowitz: Slide 20, prospectively defined. No specified depth in the protocol, this is a clinical outcome trial.

Wahbah: How many events were censored? Where all ulcers examined by the same examiner?

A: 4 events were censored

In asking about the consistency about the judgment of the ulcer was it the same person reviewing. Where the events adjudicated in the same manner? How where the data presented to the committee?

Eisen: Where ulcer complications and ulcers pre-defined as a specific endpoint?
Weiner: Did events committee use discretionary power to keep events that occurred within two weeks out of the trial?

Weiner: Was the cut off at the first six months an aproxy cutoff or was that determined after the results were known?

Slide #3, pre-specified that risk factors were to be analyzed, as a result of the data it was determined that 6 month was the best analysis

Stand: What were your estimates for ASA use prospectively? Slide 184, 185, 186 ASA use was much higher than expected, this reflects real practice. Possibly the greater use of ASA was the prolonged study

Strand: Were the distribution of risk factors in this study different than expected from the NDA database? Slide 136 over time clinical practice patterns have changed, enrolling patients at higher risk

Isakson: Renal data you had pre-specified definition from the FDA, were there any other pre-specified definitions for risk factors/AE?
Was there a pre-specified definition of what defined a renal event?
A: no Formal definition, investigator driven.

Jordan: ASA higher than the NDA trials, what part was for prophy use vs occasional use for aches and pains?
A: Slide 210 Broken out ASA use for CV vs other

Jordan: Slide 64 What is relative risk relative to? Yellow bar is the reference population. Needs to be further clarified.

Loose: Algorithm for suspected event, what number was not confirmed by endoscopy or X-ray. Of the events that were called an event, not confirmed by endoscopy or Xray. How many negative findings were there in patients who were worked up. Of the events that went to the committee what % did not meet the criteria for endo or xray. Slide 451.

Loose. Did these analyses vary by Center?

Stenson. If the investigator did not call it HTN, it wasn't HTN? A: all events are as reported by the Investigator. We have done analysis of pts pressure at baseline and end of study?
Strand: Did you see mean changes in those analyses? Slide 353

*Weiner: What is the ratio of events reported to the committee and those deemed an event?
A: we do not have the ratio of those events

*Pincus: referring to slide #64, would it be helpful to have p values on that slide. Gies agreed.

*Pincus: Did you analysis ASA use and Steriod use? Combination treatment ulcer complication rates?
A: We don't have that analysis but do have information on that, steroid use was not a risk factor on ulcer complication rate. Very small cohort of patients taking ASA and Steriods. Need a slide
Pincus: The literature emphasized this combination therapy.
Strand: this is an important point, varient risk factors in RA pts in NDA, CLASS and MUCOSA
Pincus: 15% of OA taking steroid for other reasons than OA, need to know why, ie asthma.
Strand: In the CLASS study more than 80% used ASA, How did you define ASA use in the NDA study, it looks different in the NDA study vs CLASS.
A: 12% of the patients were using ASA, 80% of those were using it chronically for CV prophy

How is the ASA use similar and different in the NDA?
What is the ASA exposure in the different populations?

Strand: What was ASA use in the Trial?
A: Slide 184 and 185,186. These are not different from the general use in the population.
Spivey: Seeing approximately 14% in class and 10% in NDA, can you really predict an increased risk? Slide 202: 16% using for CV prophy use which compares to 10% in the NDA. More pts were using ASA for CV use in the CLASS trial.

Spivey: ASA use confusing, what was the duration of low dose ASA use. Is that really different from the low dose ASA use in the NDA?
**Of the 12% ASA use in the NDA, what % was used for prophylactic use?
Weiner: if you change your defintion of low dose ASA, then you can answer the question?
*Strand have a definition for ASA use Follow it up with OA information.
Weiner: Does the duration of ASA use change the analysis? Slide 191.

When is the patient at risk when they use ASA? Geis: Did that data answer the question (slide 191)? Strand: Yes

Whelton: Separation of the primary endpoint from the secondary endpoint is troubling. Soft definition of what is symptomatic. Was there enough judgment by the PI at the site that it could have affected whether the event was considered complication vs an ulcer? Geis A: endo or contrast study. In the CLASS study they were endoscoping more frequently than in the NDA or MUCoSa. And more often the patient was more often treated early and did not go on to have a ulcer in that the PI were more apt to scope for symptoms and treat before the ulcer complication arose.

Strand: Suggest having the Consultants answering these questions, as they would pull more weight.

Pincus: Do we have data analyzed for periods shorter than the 6 months. Dr. Goldstein to review K-M graphs for the entire period. Short term steroidal more common than long term. Slide 43
Why is the 6 month analysis the most appropriate one? At 30 days there were no events.
Dr. Mackuch: A: Inappropriate to say you looked at data month by month. Executive committee reviewing data made the observation prior to reviewing analyses.
*Clarify how the decision was made to stop the study and why the 6 month data was the analysis.
Silverstein: Looked at study progress and determined that they would not obtain enough events within a reasonable period of time. The first 6 months was most uniform

Strand: Where protocols compared separately?

Strand: Why was there no interim analysis?

Freidman: Credibility of the study will be called into question, by FDA or committee members. Need a crisp answer, you will be accused of picking an arbitrary time to stop the studies, data dredging, post hoc analyses on risk factors. Did the company know what the data were and that contributed to the stopping of the study?

In the main presentation, nail and clarify what the rules were and how the company was out of the decision. Pincus liked Makuch's response.
* Have a slide with the dates and what the committee communicated to you as a sponsor.

Spivey: Not as troubled by stopping the study, there is a sense of what data are you analyzing and what data are you throwing away.

Pincus: In general, in science, you present the raw data then show the analysis visa versa from what you are doing. May not be well received.

Stenson: Did you make the statistical comparison between diclofenac and ibuprophen? Your assumption is that the toxicity of NSAIDs is comparable, this is not the case. Brings into question the validity of calling NSAIDs the same and the pooling of the data. Question the statistical appropriateness of comparing the NSAIDs.

Did we assume that the NSAID complications would be the same?
The overall event rate for NSAIDs was 1.3. The analysis plan was combined going in.
Goldstein: Slide 263

Strand: Don't the endoscopy studies show differences between diclo and ibuprophen?
Strand: Why did you use diclofenac rather than naproxen? A: In discussions with FDA, diclofenac is the most widely prescribed NSAID around the world. Goldstein: Utilization of NSAIDs over time, Slide Time to Withdrawl Due to GI Aes # 70

Loose: Discuss types of formulations used in your study compared to the commercial formulations. Do the formulations used in the study match those in the market?
*C-max data, not achieved.
Strand: Diclofenac/placebo: need to clean this up.
Friedman: Is there an NSAID compartor, how can we grant you label changes when you appear to have to different data. It is not clear that there is a difference in NSAID comparators.
Strand: Outcome shows that your drug is as good as diclo and less safe than ibu?

Strand: why did you use diclo as a comparitor?
Silverstein: Answer: first issue of GI tolerance. Second, endoscopic studies show 8-7 time reduction in incident of ulceration.
Freidman: It appears that you failed your primary endpoint?
A: Like to look at this from Statistical point of view and a clinical point of view slide 56, 57, 58, 59
Suggested answer; When we correct for the unexpected compounding factor of aspirin, the answer is no.
Silverstein: when we take ASA out, we have met our endpoint. Clinically significant reduction in GI bleeding.

Strand: In view of changing medical practice, did you meet your endpoint? Silverstein: Why did the comparator not behave the way we expected it to. There were changes in practice.

Jordan: If you look at page 100 in briefing document figure f, there still would be a question if the primary analysis was met. Polish this section of the talk, highlight changing medical practice.

Weiner: Figure 4A on page 36
Friedman: there are incredibly few GI events 34 in 8000, what is the medical benefit of your drug. Geis: 16,5000 deaths d/t NSAID complications. Dr. Goldstein: Good answer.

Isakson: Should Celebrex be reserved for patients over the age of 75 and have no CV risk factors? Dr Goldstein, slide 189.
How does this compare to other pts not taking non-steroidals and ASA, slide 83 is the slide he wants to see.
Needleman: No addition of asa can affect an nsaid because it blocks Cox 1 already.

Might discuss the topical effect of ASA.
*Show us the rates of ulcer complications for Ibu and Diclo in ASA and Non-ASA users.
Slide 200, does not get at the answer Slide 82 The study was not powered to answer the question. Slide 83 slide 84, 87, 88. Ando: feels Geis was onto something with this response shown in these slides.

Spivey: the original question minimized the pt population that would benefit from this drug. Get your talk above into the main presentation.

Strand: I am not convinced by iron and h/h factors that there isn't another source of blood loss. Slide 91. Do not infer that it is GI related source. Slide 92, how do we know this is GI blood loss, event rate increases chronic blood loss in all groups,
Bone marrow density, dysplasia We have data that is suggestive.

Do not make a claim against NSAIDs, we are trying to differentiate the drug from NSAIDs
Eisen: Where there any cases where the event would have met criteria but did not have proof of a lesion. And were they equal among treatment groups?
Dr. Goldstein responded. No slide to show
*Have slide of cases that went to adj but did not have findings.

Eisen: Where there more endoscopies in one group? Significantly more patients in the NsAId treatment arm were evaluated for complications.

Spivey: simplify the answer, symptomatic presentation so more Aes in the NSAId so there were more workups in the NSAId

Jordan: given more endos in the NSAID group b/c there were more symptoms could that have increased the number of ulcers found, an introduced a bias against the NSAID groups. Does this off set the biased of the drop out rate for symptoms in NSAID group.

Wabah: Have you seen any effect on the female reproductive system?

Loose: Do you have any evidence of bone demineralization with celecoxib? Slide 342 looking at hypophospatemia or accidental fracture, no observed effect.
Strand: Where's the Long-term safety with respect to liver failure.

*Strand: A post marking update would be very helpful, post marketing surveillence data, slide 476 - Update the slide to indicate it is through 2000 as well as bone demineralization.

Needleman: 20-25% of the NSAID data base, where is the evidence that there are 5000 less deaths and 30,000 less hospitalizations since bring Cox-1 to the market.
*Need to get these data. Geis: Aramins database has been updated, seen this data, knows the incident of hospitalization reduced but no sure about death rate.

Needleman: Are you powered in this trial to make the call of lower incidence of thromboembolic events? Dr. Zhao, data to small, trend seen.
Needleman: Is that ulcer rate due to ASA alone or is celebrex making ASA worse.
Slide 83, No combined effect. Geis: we could pull the high dose ASA users in the NDA to support no risk in taking ASA and Celecoxib.
Jordan: only 10% of patients were on ASA.
Ando: This data though not statistical shows there is no combined effect of ASA and celebrex.
Needleman: Relationship of endoscopic ulcers to ulcer complication? Slide 99, 100 Dr. Goldstein.
Up front in main presentation to answer why we did the class study, serogate marker.
Pincus: Events are not predicted by symptoms.

Presentation Critique
Needleman:
Jim: don't adjust data, it took you 18 minutes to get to the data which was rich, you need to get there.
Validating the stop rule,
Steve: pick and choose, shave 5 minutes out of history
Good strenght in liver, CV benefit of Celebrex

Establish the 6 month period, muttled by ASA answers. The whole data moved based on ASA.
*Simple clear, how many patients were on prophy ASA.
Practice with consultants each weeks

Ando: helpful to go through each section and pull out conclusions at each sections. Then pull them all together at the end.
Use a tighter link from the original NDA submission since the advisory will not be familiar with this data.
When you talk NSAID, include naproxen
General safety
*Blow up each system ie hepatic, easier to work with rather than the entire body system on one slide
Design of class trial: attention span is short, have a table with overall features, then some other features you want to look at.

Answer with data, not our opinions, use the consultants.
Spivey: Hown in on controversy during the 1/26 meeting

Naurang: Make the point that the committees are blinded throughout,
And reiterate that doses of celebrex were Supratherapeutic doses
Jim had a slide to answer what we accomplished, today it was piecemeal
*Slide showed background rate, what we learned from Aramis, class and mucosa, when you look at celecoxib alone you get as close to background rate as you possibly could.
Whelton: Jim remarks about DSMB as a member of the board, in our discussion that was appropriate, we assumed most complications were occurring in the comparator. Ethically the committee felt the study should be stopped.

* Slide 64, compare 0 risk to 1 and 2, that one risk might be age 75 which is not as significant as a prior ulcer.
* There were 35 serious events, could only count 31 events. 6 months vs entire trial, wasn't clear.
Pincus: agrees about the ethics of the DSMB reason for ethics
All the possibilities of outcome were considered

EXHIBIT 165

From: LEFKOWITH, JAMES B. [PHR/1825]
Sent: Friday, January 26, 2001 6:40 AM
To: GEIS, GEORGE S. [PHR/1825]; VERBURG. KENNETH M [PHR/1825]
Subject: FW: comments

fyi

-----Original Message-----
From: Vstrand@aol.com [mailto:Vstrand@aol.com]
Sent: Friday, January 26, 2001 6:21 AM
To: LEFKOWITH, JAMES B. [PHR/1825]
Cc: JAIN, RITA I [R&D/1825]; WESZT, SUSAN M. [PHR/1825]
Subject: comments

I'm sure you've heard more than enough from your internal and external consultants, but I spent the time reading the FDA briefing doc, and have some perspective as I know what the document for Friday's meeting looks like as well.

Clearly the division has drawn a "line in the sand" and seems to be wanting a "bloodbath" each of the three days. I'm not exactly sure why they've chosen to be so confrontational, but that appears to be the plan, and not modifiable.

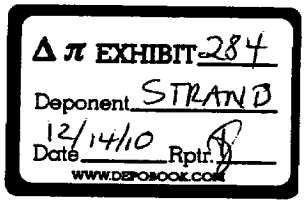
I have not seen the briefing document for Merck but I expect it isn't any better, and, in some ways worse, as I expect they will be criticized over "new and different" safety data rather than failing to meet their primary endpoint.

Regardless, [and the agency really is looking at each product individually], you can't try to convince the panel that your 'alternative' analyses were either prospectively defined and/or appropriate, since you failed to meet your primary endpoint.

I think your presentation [last week, as I missed this week's] was solid, appropriately objective, etc etc, but failed to tell the truth. You didn't prospectively define a "combined" endpoint of complications + symptomatic ulcers; and if you prospectively allowed the subset analysis of ASA users vs non -users you need to make this point more convincingly. More importantly, since the FDA has called into question even censored GI complications, you need to have ALL of your independent panel members defend the conduct of the study, and you need to have Dr. Goldstein take a back seat when explanations regarding adjudication of GI events are offered. Better to let Drs. Silverstein and/or Aggarwal field the questions, because, for better or worse, Jay (and I like and respect him alot] is perceived as just about a Pharmacia/Searle employee, esp given his geographic location. Better to let him answer a different question; or even to have your external statisticians defend conduct of the study.

You and Steve need to "field" the questions, but avoid answering any regarding conduct of the study. Otherwise the external monitoring committees are perceived as not truly external, or independent.

The other point is to emphasize "change in practice" over time. This is hard to predict, and you can openly admit that your projections and sample size calculations were wrong in several aspects. This is the major reason many of the sepsis trials failed.....after one confirmatory trial, the subsequent trial showed different results, in part because physicians now believed the



product was efficacious and treated different patients, earlier in the process, perhaps more severe; whatever.

Certainly the huge number of Celebrex prescriptions, including a previously untreated population indicated that physicians were convinced of a different tolerability trial. And the hype and marketing probably also made them far more aware of potential GI side effects, and more aggressive identification of GI pathology in the presence of symptoms.

Rather than trying to convince the panel that informed dropout occurred with Diclofenac, I'd emphasize that changes in practice resulted in:
---higher ASA use
---earlier and more aggressive work up of UGI symptoms, thus altering dropout rates as well as identification of UGI complications
and that protocol mandated discontinuations for LFT elevations added to DICLO discontinuations.

in general physician investigators were much more aware of potential NSAID toxicities now that they perceived that a therapeutic alternative was available, just as we now listen to our patients and report MTX toxicities since we have several new therapeutic alternatives.

that is not to defend the trial, rather to offer a reasoned, measured explanation for why the CLASS trial failed. Most clinical trials are flawed, because of the heterogeneity and unpredictability of human disease etc etc.

I know this is risky but you may want to discuss whether diclofenac was, in fact, a reasonable choice for a NSAID comparator. You have a failed endoscopy trial, ostensibly because generic Diclo was poorly absorbed [or so I remember, but I'm prepared to be incorrect on that fact]. Regardless, diclofenac was a poor choice, and you might make a few points by showing the disparate results using it as a comparator in the NDA supporting trials. [I'm not suggesting you say that it was a poor choice prospectively, but that inview of previous results, it could have been anticipated that it might be problematic. This doesn't allow you to use 'informative censoring" to fully explain results, but does put this trial in the context of a large number of clinical studies which yield unanticipated results.

Finally, I'm not a gastroenterologist, but I'm not entirely clear that I agree with the censoring of UGI events. Ostensibly it doesn't change the results, but one of your more "hands off" gastroenterologists need to defend their committees decisions, and neither you nor Steve should go near this explanation.

In the end, if you offer a reasonable, measured explanation of "your interpretation" of the data; admitting openly that you didn't meet the primary endpoint, that the combined endpoint is a post hoc analysis, etc etc....you may be able to convince the panel that you are potentially better than Ibuprofen, which, obviously, is less GI toxic than diclofenac.....you won't have a chance if you don't openly concede that the events in the trial, outcomes, etc were a surprise; that you abided by external monitoring decisions, etc etc.....

That would be quite an accomplishment.....Then you still have to explain why the events in the Celecoxib group continued whereas the other NSAID treatment groups stabilized.

Perhaps the best outcome would be that you avoid additional labeling concerns

regarding cardiovascular and renal events.

It is clear to me this division is out for blood. you won't win such a battle. even if you did, I'm almost sure the division would ignore any recommendations from the panel, as they often do.
better to present the data as they occurred, analyses as prospectively defined, and subsequent analyses as supportive only and to leave with your respect in tact. That way you will be able to return with subsequent data with this product, or to defend a follow on product, and you will not risk losing credibility.

FDA always understands we physicians do what we are forced to do based on our corporate culture [and biotech in the early days was a real lesson in this respect], but they are far more cooperative in subsequent interactions if you haven't tried to convince them or the panel that posthoc analyses validate an already flawed trial.

Remember, they helped design the trial, in a fully collaborative fashion. they must bear some of the "blame" that it failed to show the expected results. Be open about this, I see this as the only way you may be able to salvage any of the positive findings.

Other "supportive", suggested points:

Emphasize the "flat dose response" with Celecoxib [also apparently true for Vloxx]; already clearly demonstrated, and mechanistically rationally explained. Take Dr. Witter's argument and turn it around: since Diclo was less well tolerated, what would it have been if used in "supra-pharmacologic" doses? only speculative, but that's one of the positives: dose creep does NOT result in better efficacy, yet the same safety profile with Celecoxib, compared with traditional NSAIDs.

Change in practice includes change in perception of prescribing MDs. now go to GI workup sooner. etc etc

Can you prove that risk factor analysis was sufficiently prospectively defined to allow the ASA and nonASA subset analyses? without invoking the "post hoc analysis" argument?

You've shown that UGI symptoms appear to "predict" events, and confirm the endoscopy trials supporting the NDA. Can you show their temporal relationship?

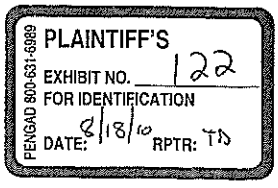
CLASS is a large "simple" [ha! ha!] clinical trial designed to mimic clinical practice. If non-GI AEs in this trial are numerically but not statistically different between treatment groups of approximately 2000 over 6 or more months, then how can it be argued that there are differences?

EXHIBIT 166

From: Zwillich, Samuel H
Sent: Tuesday, May 02, 2000 4:03 PM
To: Loose, Leland D
Subject: CBX-0078830_ Comments on CLASS draft report

CBX-0078831_
CLASS report.doc

Samuel H. Zwillich
Clinical Research / CRAH



Although conclusions like "The increase in the observed rate associated with celecoxib is clearly attributable to concurrent low-dose aspirin use." may be overstated, I am basically comfortable with the analysis of aspirin's effects. The increased use of aspirin in CLASS compared to previous celecoxib studies may account for some of the unexpectedly increased rate of CSUGIEs/GDUs: "Of note, the incidence of low-dose aspirin use in this trial was approximately twice that seen in the previous celecoxib controlled trials, but similar comparable to that observed in the general population. (13)". It should, however, be possible to estimate CSUGIE/GDU rates attributable to low dose aspirin from the literature and compare those with the rate of excess events.

I am less comfortable with blaming the lack of difference in CSUGIE rates between celecoxib and diclofenac on the higher withdrawal rates on diclo for GI AEs that would have otherwise evolved into GDUs then CSUGIEs. About half of all CSUGIEs in CLASS (and the literature) were **not** preceded by warning symptoms, so, on that basis, diclo assigned subjects should still have experienced excess events at about half the predicted rate. And while it is true that AE withdrawal rates on diclo were higher than on celecoxib (27.1% vs. 22.7% over entire study period, T2.3), if you look at T42.1, AEs causing withdrawal, Gastro-intestinal System Disorders, and add up those terms that represent UGI AEs that should not have been CSUGIEs/GDUs (abdominal fullness, abdominal pain, dyspepsia, eructation, esophagitis, gastritis, GE reflux, hiatal hernia, nausea and vomiting), the absolute numbers are small: 455/3987 or 11.4% celecoxib vs. 315/1996 or 15.8% diclo. It seems a stretch to imply that ~10 of those ~80 excess diclo subjects with GI AEs would have gone on to CSUGIE/GDUs had they remained on diclo. Further, if our message then is that the real difference between celecoxib and diclo is tolerability, not safety, (because diclo GI intolerant patients D/C the diclo before their CSUGIE/GDUs) then aren't we feeding into the school of thought that argues COX2SI are unnecessary before patients get symptoms on NSAIDs?

I am uncomfortable with the statement: "Moreover, celecoxib's association with the same risk factors as NSAIDs is in part by virtue of concomitant aspirin use, which would be predicted to cause events in those with NSAID risk factors." Since aspirin explains only part of the shared association, does that imply that the other part of the association is due to an intrinsic UGI toxicity shared between celecoxib and NSAIDs, which is not the message we want to send?

In the Vioxx SBA, at least one FDA reviewer stated a belief in the reality of GI mucosal adaptation to the effects of NSAIDs, leading to a flattening of (the equivalent of) CSUGIE incidence curves after the first month or so of Rx. Perhaps we need the data on how many subjects were on NSAIDs at Baseline to handle this issue, since a number of uncensored CSUGIEs occurred during the first month of the study (1 on celecoxib, 5 diclo, 4 ibu, Table T14.1) which they agency may want to "discount" or analyze separately.

It's interesting that steroid use didn't appear as a significant risk factor for CSUGIE/GDUs (T30.1-4). I always found attractive the model that steroids delay wound healing and therefore amplify the risk that NSAID erosions will not heal and instead will grow into ulcers.

The number of unreported/unadjudicated and therefore presumably uninvestigated subjects with extreme drops in H/H is large (Text Table 10.p). These drops are blamed on GI bleeding, rather than hemodilution, etc, and therefore raise the possibility that many UGI events were clinically silent bleeds that the event analysis algorithm missed and that only showed up as drops in H/H, which the PIs also missed! Not only does this call into question the premise of CLASS, to capture all GI events prospectively, but the missed events may have been distributed differently than those which were recognized and counted. For example, in the same analysis of extreme lab values, it is written (page 188): "The analyses performed according to aspirin status were distinct from the results presented in the "**Error! Reference source not found.**" section, namely, the addition of aspirin increased the incidence rate (of extreme drops in H/H) in all treatment groups, but preserved the differences among the groups."

Smaller issues:

Page 6, SYNOPSIS, Table 4: mislabeled 26 instead of 52 weeks

Page 50, Table 6.d, ferritin values don't distinguish patients with active inflammation (RA) and those who don't (OA)

Case 1099, subject is on 'Triamterene/hematocritZ"instead of "Triamterene/HCTZ"!

Case 1343 had gastrectomy, was enrolled in violation of the protocol and had an event. That was the only blatant violation I caught in the cases, but I may have missed others while skimming.

SAEs (T43): Cellulitis in 8 on celecoxib vs. only 1 each on diclo and ibu (4 times the rate), although, fortunately, events classified as "resistance mechanism disorders" were similar in all 3 treatment groups. Cardiac failure was seen in only 0.4% (9) celecoxib subjects, ½ the rate on ibu, which is reassuring in light of recent publicity about NSAIDs [redacted]

The small fall in mean WBC and platelet counts on celecoxib compared to the small rise on the comparators (Table T44.1) may reflect a modestly increased anti-inflammatory effect of celecoxib at the high dose compared to diclo and ibu.

EXHIBIT 167

From: NEEDLEMAN, PHILIP [EXC/1005]
Sent: Tuesday, June 04, 2002 2:47 PM
To: GEIS, GEORGE S. [R&D/1820]; VERBURG, KENNETH M [R&D/1825]; LEFKOWITH, JAMES B. [R&D/1825]
Cc: JOHNSON, WILLIAM J. [R&D/1825]
Subject: CBX-0345478_RE: BMJ editorial

How can we explain this more simply-otherwise the message will be lost? Actually I don't understand why there would be a difference in hazard rates. It is important to understand the numbers-if most of the events in the second 6 mo were celecoxib it is difficult to rationalize because there still were plenty of NSAID patients left (the drop depletion numbers while signif different weren't that profoundly different).

This is one of those "hot seat" times that comes with such a big drug-which is such an attractive target for reporters, analysts and esp HMOs.

-----Original Message-----
From: GEIS, GEORGE S. [R&D/1820]
Sent: Monday, June 03, 2002 8:55 PM
To: NEEDLEMAN, PHILIP [EXC/1005]; VERBURG, KENNETH M [R&D/1825]; LEFKOWITH, JAMES B. [R&D/1825]
Cc: GEIS, GEORGE S. [R&D/1820]
Subject: RE: BMJ editorial

Phil,
I spoke with Ken as he was boarding a plane for Peapack today and agreed that I'd respond to your queries.

I will get the detailed data tomorrow and forward it to you - however, in the interim note the following:

1. I need to confirm the numbers - but if it is true that almost all the ulcer complicationS in the second half of the trial were with celeocoxib - this would not be unexpected since the biases of the study had the greatest impact after 6 months. The explanation of this is al follows"

a. The hazard rate for NSAID complications was expected to be constant over time. See Slide # 1 of the attached deck. We also assumed that hazard rate in the celecoxib treated group would be constand over time, as well.

b. Based on PHA analyses, the hazard rate for the NSAIDS did NOT remain constant in CLASS. However, the hazard rate did remain constant in the celecoxib group. (Slide # 2. Of note - Bob Makuch confirmed the analysis for the external authors preparing the longer term manuscript.)

c. The decrease in the hazard rate for NSAIDs in CLASS was due to higher depletion of the susceptible patients with time in the NSAID group versus the celecoxib group. One of the most susceptilbe patient groups was the group of patients who had an ulcer. As seen in Slide # 3 - a significantly higher proportion of NSAID patients were withdrawn due to the presence of a symptomatic ulcer. The p-value on the slide compares the two curves overall but you can see that the curves separate more after 6 months.

d. Another factor that contributes to the apparent higher rate of complications in the celecoxib group after 6 months is the proportion of patients taking low dose ASA (~22%).

(1) Low dose ASA causes ulcer complications (Slide # 4).

(2) Our endoscopy data suggested that low dose ASA is a risk factor for ulcers in celecoxib users but NOT in NSAID users (Slide # 5) .

(2) Makuch performed an analysis showing that the hazard rate of ulcer complications in the celecoxib group not taking ASA was constant with time but was lower than the combined group ASA and non-ASA users.

2. For your second question I need to check the numbers. However, the issue is the withdrawl of **susceptible** patients - not the withdrawls for any reason.

Give me a call if you want to go over this in detail.
<< File: CLASS Questions.ppt >>
Steve

-----Original Message-----
From: NEEDLEMAN, PHILIP [EXC/1005]
Sent: Monday, June 03, 2002 3:36 PM
To: VERBURG, KENNETH M [R&D/1825]; LEFKOWITH, JAMES B. [R&D/1825]; GEIS, GEORGE S. [R&D/1820]
Subject: RE: BMJ editorial

ken-what is the data and the appropriate answer to the authors claim that: 1) almost all the ulcer complications in the second half of the trial were with celecoxib; and 2) their assertion that the withdrawal rates were essentially the same across groups and were gradual in the second half of the study?

-----Original Message-----
From: VERBURG, KENNETH M [R&D/1825]
Sent: Monday, June 03, 2002 2:31 PM
To: NEEDLEMAN, PHILIP [EXC/1005]; LEFKOWITH, JAMES B. [R&D/1825]; GEIS, GEORGE S. [R&D/1820]
Subject: RE: BMJ editorial

Phil-
we don't have a formal response prepared (maybe PR does however). I have attached the Silverstein Letter to JAMA and below are the responses the Steve that gave to NY times. Need more - let me know.

<< File: Final Silverstein JAMA Letter 1121.pdf >>

Study Finding Celebrex Safer Was Flawed, Journal Says

June 1, 2002
By MELODY PETERSEN

An editorial in the June 1 issue of The British Medical Journal harshly criticizes a scientific study that the drug company Pharmacia used to promote Celebrex, the arthritis drug that is its best-selling product.

Its authors said the study, which concluded that Celebrex, which had $3 billion in sales last year, was safer than other widely used pain relievers because it caused fewer ulcers, had "serious irregularities."

They also said Pharmacia's previous explanation for discrepancies in the study was "inadequate." Doctors should be informed, they added, that the conclusion that Celebrex was safer than drugs like ibuprofen had been contradicted.

"The flawed findings published in the original article appear to be widely distributed and believed," wrote Dr. Peter Juni, a senior researcher at the University of Berne in Switzerland, and two other doctors. If Pharmacia is not required to inform doctors that the study's conclusion was invalid, they said, "the pharmaceutical industry will feel no need to put the record straight in this or any future instances."

Dr. Steve Geis, Pharmacia's vice president for clinical research, said yesterday that the company disagreed with the editorial. The Celebrex study used "appropriate scientific judgment," and the company stands by its conclusion, Dr. Geis said.

Celebrex and Vioxx, a similar medication sold by Merck & Company, are some of the most heavily advertised prescription medicines.

The drugs, known as Cox-2 inhibitors, have grown increasingly controversial because they have not been shown to reduce pain better than drugs like ibuprofen and naproxen, which are available in generic and over-the-counter versions, at a fraction of the cost.

The companies have said the new drugs are worth their high price because they are safer for the stomach and appear to cause fewer ulcers, a dangerous side effect of anti-inflammatory pain relievers like ibuprofen and aspirin.

The popularity of the two drugs has alarmed health insurers, as the cost of caring for arthritis patients has increased greatly. A month's prescription of either Celebrex or Vioxx costs about $80, many times the cost of generic pain relievers.

Many insurers and doctors say the new drugs should be prescribed only for people at risk for ulcers.

But Pharmacia is still struggling to convince the Food and Drug Administration that Celebrex is easier on the stomach. The agency and the company are discussing whether Celebrex's label should be changed to say the drug causes fewer ulcers and allow to advertise that claim. Much of the data that Pharmacia has presented to the agency to prove Celebrex is safer are those that the editorial's authors criticize.

The editorial focuses on a study reported in 2000 in The Journal of the American Medical Association. The study concluded that patients taking Celebrex suffered fewer serious ulcer complications than those taking ibuprofen or diclofenac.

About a year later, an article in The Washington Post disclosed that Pharmacia's published study included only the first six months of data in a study that had lasted a year. When all the data are analyzed, Dr. Juni and his colleagues said, much of Celebrex's safety advantage appears to disappear because almost all of the ulcer complications in the last six months occurred in Celebrex users.

Pharmacia and the doctors it hired to prepare the study, including professors from Harvard and Yale medical schools and six others, have said they omitted the last six months of data because many patients dropped out in that time, skewing the results. The high drop-out rate, they said, left more patients at risk of ulcers in the Celebrex group than in the groups taking the other drugs.

But Dr. Juni and his colleagues called that explanation "inadequate." The patients who dropped out, they said, did so gradually over the year of the study, without a sudden increase after six months.

Dr. Juni and the other authors said Pharmacia appeared to have widely distributed reprints of the Celebrex study.

Thirty thousand reprints were purchased from the publisher, and the study was cited in 169 other medical articles, they said.

Dr. Geis said he did not know how many reprints the company distributed, but he said it regularly distributed copies of medical journal articles about its products if doctors requested them.

The doctors Pharmacia hired to help it perform the study are working on a more detailed explanation of why the study was appropriate, Dr. Geis said. Even as the study was being designed, he said, the company and the outside investigators believed that six months of data would provide the best answer about Celebrex's safety. The study continued, he said, to determine what happened over a year.

"The most meaningful answer," he said, "is in the first six months."

-----Original Message-----

From: NEEDLEMAN, PHILIP [EXC/1005]
Sent: Monday, June 03, 2002 2:22 PM
To: LEFKOWITH, JAMES B. [R&D/1825]; VERBURG, KENNETH M [R&D/1825]; GEIS, GEORGE S. [R&D/1820]
Subject: BMJ editorial
Importance: High

Do we have a quick response to the editorial? If so can you pls email me a version.

EXHIBIT 168

FOR INTERNAL USE ONLY; NOT TO BE SHOWN OR GIVEN TO ANY EXTERNAL AUDIENCES – FEBRUARY 9, 2001

Q&A: FDA ADVISORY COMMITTEE HEARING ON PROPOSED GI SAFETY LABEL REVISIONS FOR CELEBREX®

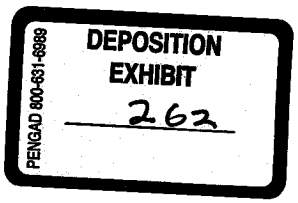
Q. What was the role of the U.S. Food and Drug Administration (FDA) Arthritis Advisory Committee?

A. The role of the FDA Arthritis Advisory Committee was to provide guidance and recommendations on modifications to the CELEBREX label based on the findings from the Celecoxib Long-term Arthritis Safety Study (CLASS). The committee's recommendation is one piece of input that the FDA will take under advisement when making a decision regarding the CELEBREX label in the United States. It is important to realize that the advisory committee's recommendation is part of a continuing discussion we will be having with the FDA regarding CELEBREX label modifications.

Q. What was the Arthritis Advisory Committee's recommendation regarding the CELEBREX label?

A. Due to the complexity of the CLASS data, the advisory panel on day one (February 7) experienced difficulty interpreting the results.

After reviewing data from VIGOR study on February 8, the Committee subsequently provided guidance that the labels for both CELEBREX and VIOXX should reflect data showing gastrointestinal safety advantages versus specific comparator NSAIDs studied.



Q. Will there be label modifications resulting from the CLASS findings with diclofenac?

A. In CLASS, CELEBREX, at four times the recommended osteoarthritis (OA) dose, demonstrated significantly fewer symptomatic ulcers and ulcer complications in a pooled analysis of the NSAID comparators (ibuprofen and diclofenac), as well as ibuprofen on its own. We will work with the FDA to include these data in the CELEBREX label.

Q. What was the recommendation of the committee regarding the VIOXX label in relation to GI safety? [redacted] Non-Resp.

A. The committee provided guidance to the FDA that the labels for VIOXX, as well as CELEBREX, should reflect data showing gastrointestinal safety advantages versus specific comparator NSAIDs studied. [redacted] Non-Resp.

Q. What did Merck ask the committee for in terms of amendments to their label and did this differ from Pharmacia's request?

A. As with Pharmacia, Merck requested label modifications that reflected long-term GI safety data from the VIGOR trial. The requests from the companies reflected differences in study design.

The CLASS study was rigorous and reflected "real world" clinical practice by enrolling both OA and rheumatoid arthritis (RA) patients regardless of age and disease severity and allowing use of low-dose aspirin—a known ulcer-causing agent—for cardioprotection.

On the other hand, VIGOR studied RA patients only and did not allow for prophylactic use of aspirin. Additionally, the primary endpoints and comparators in each trial were different.

Q. **How will the FDA Arthritis Advisory Committee's discussions affect the promotion of CELEBREX?**

A. Nothing has changed in our promotion due to the advisory committee meeting. Discussions with media and customers should reinforce that CELEBREX is as effective as NSAIDs with significantly improved GI safety and tolerability. Previous studies comparing CELEBREX to traditional NSAIDs in approximately 20,000 patients, post-marketing surveillance in more than 12 million patients and nearly 2 million patient years of exposure have demonstrated that CELEBREX is effective, well-tolerated and offers an excellent GI safety profile.

Q. What is Pharmacia's reaction to the Advisory Committee's recommendation?

A. We believe that the data from CLASS present a compelling case that warrants inclusion of the CLASS data in the CELEBREX label.

The recommendation from the committee is an important part of the on-going process of review that the FDA Advisory Committee will take into account when considering changes to the CELEBREX label in the U.S.

CLASS Q&A:

Q. How was CLASS designed to replicate "real world" clinical practice?

A. Celecoxib Long-Term Arthritis Safety Study (CLASS) was designed as a "real world" study to replicate everyday clinical practice by prospectively studying 8,000 patients regardless of age, disease severity or prophylactic aspirin use—a known ulcer-causing agent.

Q. What are the key implications for CLASS?

A. CELEBREX® (celecoxib capsules), at four times the recommended OA dose, was effective and showed significantly fewer symptomatic ulcers and ulcer complications than the NSAIDs studied (ibuprofen and diclofenac combined) as well as ibuprofen alone, one of the most commonly prescribed and well tolerated traditional NSAIDs.

CELEBREX-treated patients experienced significantly less GI blood loss as compared to the NSAIDs studied, regardless of aspirin use, a known ulcer-causing agent.

[redacted] Non-Resp.

Q. Does CELEBREX offer any safety advantages for patients taking aspirin?

A. Aspirin is a known ulcer-causing agent, and as such did increase the rate of symptomatic ulcers and ulcer complications in CELEBEX and ibuprofen patients. Regardless of aspirin use, CELEBREX-treated patients experienced significantly fewer symptomatic ulcers and ulcer complications, less GI blood loss and fewer effects on the kidney such as hypertension and edema as compared to ibuprofen.

Q. Should the CLASS results apply to other COX-2 inhibitors like VIOXX?

A. No. Results from CLASS are exclusive to CELEBREX and cannot be generalized to VIOXX because of the differences in study design and in the clinical profiles of each drug.

Q. Why did more patients taking diclofenac withdraw from the study than patients taking CELEBREX?

A. In CLASS, significantly more patients taking diclofenac withdrew from the study due to a GI adverse event than did patients taking CELEBREX. Although statistically significant comparisons between CELEBREX and diclofenac could not be determined, this finding suggests that patients are more likely to continue with chronic CELEBREX treatment than chronic treatment with diclofenac because they find it more tolerable.

# # #

BEGNO	ENDNO	DATETIME	DOCDATE	AUTHORNAME	CUSTODIAN
DEFS 00754326	DEFS 00754329		03/12/2001	Greg Lugliani	Geis, Steve

EXHIBIT 169

Q4 2000

Pharmacia Corporation
Moderator: Hakan Astrom
February 12, 2001
11:00 a.m. EST

OPERATOR: Good morning, ladies and gentlemen, and welcome to the Pharmacia fourth quarter earnings release teleconference. All participants are on a listen-only mode and the floor will be open for questions and comments following the presentation.

It is now my pleasure to turn the floor over to your host, Senior Vice President Strategy and Corporate Affairs, Mr. Hakan Astrom. Sir, the floor is yours.

HAKAN ASTROM, SVP STRATEGY/CORPORATE AFFAIRS, PHARMACIA CORP.: Thank you, operator. Hello, and welcome to our fourth quarter conference call, and thank you for joining us today. Today, for the first time, we are also webcasting this conference call, and this can be accessed at our web site, www.pharmacia.com.

Before proceeding, counsel has asked that I refer you to the final page of the release for information regarding any forward-looking statements made during this call.

Joining me this morning for the call here in our Peapack headquarters are Fred Hassan, CEO; Chris Coughlin, our Chief Financial Officer; and Carrie Cox, President of Global Business Management. I'll now turn the call over to Fred Hassan for opening remarks.

FRED HASSAN, CHIEF EXECUTIVE OFFICER, PHARMACIA CORP.: Thank you, Hakan, and good morning, everyone. It's a real pleasure today to be reporting on an exceptional first year for Pharmacia Corporation. This was a year of transformation, providing a solid foundation for long-term growth. It was just over 13 months ago that we announced the creation of this new company.

At that time, you'll recall that we promised a lot. We predicted that our merger would create a new, top-tier competitor delivering top-tier growth. As you know, it took some time for our conviction to be shared. We worked very hard to gain the trust of our investors. So it's very satisfying for me to report that during 2000, we achieved our goal. We kept our promise. We rewarded the trust of our shareowners. We delivered a 72 percent increase in our share price during 2000. This ranks us first among the big pharmas.

As you'll see from this morning's release, we've delivered 31 percent growth in EPS for 2000. That growth puts us at the top of the big pharma league. In the fourth quarter, we delivered 33 percent EPS growth. This puts us ahead of all of our piers for the quarter. The fourth quarter performance also continued the robust growth we achieved in each quarter of 2000 while we carried out one of the fastest global mergers on record. We are particularly pleased that our EPS growth was driven by double-digit sales growth for the corporation overall.

PLAINTIFF'S EXHIBIT 401 Hassan DAC 2/28/11

As we had planned, the main engine of our sales growth was our human prescription pharmaceuticals business, which grew by 17 percent for the year, led by very strong 26 percent increase in the United States. We now get 56 percent of our Rx sales from the U.S. This is right in line with our strategic goal.

Meantime, our Ag business was also the leader in its peer group. In the face of a very difficult environment in 2000, Monsanto recorded seven percent sales growth for the fourth quarter and five percent growth for the full year, well ahead of its closest competitors.

As you will recall, when we first announced our merger, there was considerable pressure on the Ag business. In response, management of Pharmacia and Monsanto have taken actions to resize the Ag business and refocus our Ag R&D around four key crops. I'm pleased to report these actions have put the Ag business on a strong financial footing.

So we feel we can be very pleased with the growth story of Pharmacia in 2000. Even more importantly, however, we believe that we've built a very strong foundation for long-term strength and long-term growth. As you know, most mergers fail. Of those that survive, many do not deliver on their promise. By contrast, the long-term picture for Pharmacia is very exciting. We have put together two smaller companies and created a global powerhouse. As we promised at the time of the merger announcement, one plus one truly does equal more than two at Pharmacia.

Over the past year, we have swiftly integrated our pharmaceutical business into one strong global operation. Our successful limited IPO of the Ag business last fall reflects the teamwork and execution focus of our management group. We are very pleased that we're beginning to see the value upgrades we anticipated in the Monsanto business at the time of the merger. This is visible in Monsanto's share price, which has appreciated by more than 50 percent since the IPO in October. Exceptional teamwork across the organization has kept our registrations and filings on track. Our R&D organization is functioning well, and we're seeing a good product flow picture.

I would like to emphasize something very special about Pharmacia's profile. We have an unusual dual strength. We have a top-tier exclusivity profile on all of our long-term growth products, and we also have a top-tier freshness index; that is, a percentage of our important products that have been on the market for less than 10 years. This is a unique advantage for Pharmacia going forward.

As you know, we have filed parecoxib, our injectable pain medication. We continue to feel very comfortable with the profile of parecoxib. It's another demonstration of the exceptional strength of our COX-2 platform. And valdecoxib is right on track.

This quarter, we're continuing the successful rollout of our revolutionary hospital antibiotic, Zyvox, with our first European launch in the U.K. We're also very pleased with the approval of Detrol LA in the U.S. Detrol LA is our once-daily treatment for overactive bladder, and it will further enhance our leadership in this area.

I would like to take just a moment to comment on some recent developments regarding Celebrex. We had an interesting two days last week when the U.S. Food and Drug Administration advisory committee, the arthritis advisory committee, met to review the request to remove the classical, non-steroidal anti-inflammatory drug warning from the Celebrex and Vioxx labels. At the end of the two days, the committee did not accept that the warnings should be removed, but it did recommend that the additional positive safety data versus older products, such as ibuprofen, be added to the labels for both products.

We also noted that the committee took the position that our competitor's product should have data on potential cardiovascular side effects included in their labeling. There was no such action regarding Celebrex. As many of you have seen, there were early incorrect reports from the committee hearings suggesting that they gave an advantage to our competitor's product. However, we're pleased to see that recent reports by many of you on the line are beginning to present a fuller picture. As those reports suggest, we feel very good about the hearing and we can also feel very good about the competitive position of Celebrex in the COX-2 marketplace.

We now look forward to working with the FDA on an improved label for Celebrex, and we feel confident that Celebrex will now grow into an even bigger and more important treatment for patients and physicians around the world. As you know, not long ago, many people were predicting that the sales leadership held by Celebrex over our competition would be eliminated, and even that we would be overtaken in the United States. We're pleased to prove that that prediction was not accurate. Over the past month, we have retained our leadership in the COX-2 market.

Now we're also focusing on Europe. One of the key benefits we saw in our merger was the opportunity to create a very strong competitor outside the U.S. by combining our Searle and Pharmacia and Upjohn teams. We're glad to see this happening. Although we entered the COX-2 arena later than our competition in Europe, in market after market we're now overtaking our competition. We expect that momentum to continue.

This growth of Celebrex reflects the long-term strength we're building within the Pharmacia organization. We are creating a distinctive culture at Pharmacia - a culture that I believe will give us a real competitive advantage for the long run. We are creating a highly collaborative way of working in teams across units and geography. We're intent on making this dynamic, collaborative, trust-based approach a hallmark of our relations with our customers and other stakeholders. This way of working is driving our success in the U.S. and our core markets. It's what makes me personally so excited about our long-term prospects.

Finally, let me comment on our outlook for 2001. As we've said many times before, we remain committed to our goal of 20 percent annual compounded earnings growth from '99 through 2002. This remains our goal for 2001, despite the much more challenging environments that we face.

One very important external factor will be the U.S. political and policy situation over the coming year. It will be essential that our industry build a much better understanding of the enormous value of pharmaceuticals to society and to individuals. We must also build public understanding

of the importance of sustaining pharmaceutical innovation. In particular, we must ensure an understanding that price controls would deeply undermine this innovation.

To achieve these goals, we in the pharmaceutical industry must visibly take an active role in resolving some of the key issues surrounding health care access. That includes, as a top priority, securing drug coverage for seniors in the U.S. who currently lack such coverage. We must help build a consensus that the issue is not drug prices. The real issue is coverage.

So we're cautiously hopeful that our industry will be able to work with the new administration and the new Congress to achieve drug coverage for all seniors while preserving the free market system in the U.S. that sustains innovation. I personally will be devoting substantial time to this effort because I believe it's a key to delivering on the exciting promise of our industry – that is, to create a new golden age of health and wellness in the coming decade.

And now I'll turn over the call to Chris Coughlin, our CFO – Chris.

CHRISTOPHER COUGHLIN, EVP/CFO, PHARMACIA CORP.: Thank you, Fred. As I discuss our performance for the fourth quarter and for the year, I will be referring, as usual, to our results on an adjusted basis. This adjusted basis provides more clarity on our operating results as it excludes items like restructuring, merger-related costs, and the impacts of accounting changes.

As you have heard, Pharmacia finished the year with a strong quarter in both its pharmaceutical business and its Monsanto Ag business. Our 33 percent growth in net income for the year has been driven by three main factors - sales growth of our prescription medicines business, synergies from the merger, and cost reduction initiatives at Monsanto.

Looking at our fourth quarter results, the sales increase of eight percent was negatively impacted by foreign exchange of five percent. In local currency, our prescription business continued its strong growth at 16 percent. Our U.S. prescription product sales grew 20 percent. For the full year, our prescription medicine sales grew 17 percent in U.S. dollars and 20 percent excluding the negative impact of foreign exchange, well in line with our aggressive merger targets. For the quarter, our earnings before interest and tax, or EBIT, grew 32 percent, and our earnings before tax grew 44 percent over last year. This increase in earnings before tax reflects reduced debt levels from a year ago.

Our earnings per share grew 33 percent for the quarter and 31 percent for the full year. While all quarters of 2000 will have to be restated to reflect the impact of changes in revenue recognition within our Monsanto Ag business, this accounting change due to SAB101 has no impact - again, it has no impact - on our full-year EPS of $1.45. The change only impacts individual quarters. We will issue fully restated P&Ls for the four quarters of 2000 later this month.

Our fourth quarter performance continued to reflect an improved profit margin picture for the company. Our pharmaceutical gross margin improved 200 basis points to 78.7 percent, offsetting gross margin declines in Monsanto. Our total company EBIT margin improved by 2.5

percentage points to 13.8 percent in the quarter, while for the full year the company improved its EBIT margin by 200 basis points to 16.3 percent.

Our Monsanto business had an EBIT of $46 million in the quarter versus a loss a year ago. This reflects impact of our cost-containment efforts as well as the termination of certain research and development projects done earlier this year.

I will also point out that our pharmaceutical EBIT growth in the fourth quarter of 14 percent was impacted by a milestone payment included in the fourth quarter of 1999. Excluding that milestone, our pharmaceutical EBIT grew 22 percent in the fourth quarter of 2000. As noted in the release, aggregate merger and restructuring charges totaled $327 million in the quarter and $1.2 billion for the full year.

I am pleased to say we are well ahead of our merger plan, both in terms of timing and in cost savings. We are confident that when completed, we will be well within our estimated costs of $2 to $2.5 billion, while exceeding our cost-reduction targets. In fact, for the year 2000, we realized pretax savings from our merger of $290 million, more than double our original estimate. In addition, restructuring activities in our Monsanto business generated an additional savings of more than $80 million.

I would also like to highlight that we are well ahead of our debt reduction targets. You will recall, at the time of the merger, we established a target to reduce our net debt from $6.5 billion at the end of 1999 to $4.5 billion at the end of 2000. This target did not include any anticipated proceeds from the Monsanto IPO. As of December 31, 2000, our net debt was $3.2 billion, which includes the impact of approximately $700 million in IPO proceeds. So you can see, we beat our target by $600 million.

Looking forward to 2001, we expect another year of significant growth. Sales growth should continue at the double-digit level in our pharmaceutical business, led by our Rx business, which will continue to grow faster than our overall pharma business. We anticipate that the top-line growth of the Ag business in 2001 will be in line with its 2000 growth rate. We anticipate an improved environment for product approvals from Monsanto, which will improve our sales growth prospects post-2001.

On the earnings front, we again look for a very strong growth from Pharmacia in 2001. We anticipate that our earnings from continuing operations - that is, before the minority interest of our Monsanto business - will grow in excess of 20 percent. We also expect that our 2001 earnings per share, including the dilutive impact of the minority interest in Monsanto, will grow in the range of 20 percent. This aggressive growth outlook is right in line with our merger plan.

I should also point out that, in both 1999 and 2000, Pharmacia's pretax earnings included approximately $145 million of income recognized from partnership payments on COX-2 collaborations. These collaboration payments were not impacted by the new SAB101 guidelines. It should also be noted that these COX -2 collaboration payments will not repeat in 2001 or

thereafter. So if you exclude these payments from our 2000 base, we would estimate our consolidated income will grow in the range of 25 to 30 percent in 2001.

2001 will also be the last full year of our U.S. marketing agreement with Sanofi-Synthelabo for Ambien. The profit split on this business reduces from 60 percent to Pharmacia in 2000 to 53 percent in 2001. In April 2002, Sanofi-Synthelabo will regain its full rights to Ambien and will make a final settlement payment to Pharmacia. Our income in 2002 from Ambien will actually increase due to this final settlement. Pharmacia will continue reporting 100 percent of sales through this year and the first quarter of next year. The Sanofi portion of the profit will continue to be reported as an expense in other income and expense. There will be no income reported from this product after 2002.

In anticipation of losing the full-year sales and earnings from Ambien in 2003, it is our intention to continue to aggressively pursue licensing and product acquisition opportunities. As you know, these investments may require up-front payments that are not included in our current earnings guidance.

In summary, we are pleased with our outstanding 2000 results, the rapid execution of our merger, and the integration of our new organization. These actions position us very well for future growth. We therefore continue to be confident in our ability to meet our aggressive target of 20 percent compound annual growth rate in earnings through 2002.

Now let me turn the discussion over to Carrie Cox for more details about our pharmaceutical business.

CARRIE COX, PRESIDENT, GLOBAL BUSINESS MANAGEMENT, PHARMACIA CORP.: Thank you, and good morning.

As you've heard, Pharmacia has had an exception year. Our total commercial Rx sales increased 17 percent over last year to $10.8 billion. The fundamentals of our global Rx business remain strong, with significant growth by our top products - Celebrex, Xalatan, Ambien, Detrol, Camptosar, and Zyvox. Fourth quarter sales of these six products amounted to $1.4 billion, a 40 percent increase over the fourth quarter last year, and annual sales were $4.9 billion, a 58 percent increase over 1999. Our five long-term growth drivers - Celebrex, Xalatan, Detrol, Camptosar, and Zyvox - comprised 42 percent of prescription pharmaceutical sales compared to only 32 percent a year ago.

Global sales of Celebrex for the quarter totaled $772 million, up 55 percent over the same period last year. For the year, Celebrex reported sales of $2.6 billion, about a half-billion dollars ahead of its closest competitor; a spread that has been maintained consistently since the merger, reflecting the strength of the new Pharmacia.

Celebrex continued its strong growth as the world's best-selling prescription arthritis drug, also now coming on strong in Europe. Celebrex is the best choice for arthritis patients because it is

effective and better tolerated, with fewer long-term safety trade-offs, than either traditional NSAIDs or Vioxx.

I'd also like to add some context to the recent FDA advisory committee discussions around the Celebrex outcomes trial data. Our goal is to have the data included in the label, and we believe FDA will support that as the committee did.

Celebrex was proven safer than older NSAIDs in its NDA trials, through endoscopy measures, and now again in long-term clinical use. Patients who took even four times the normal dose of Celebrex still have two- to threefold fewer serious gastrointestinal complications compared to those receiving standard doses of traditional NSAIDs. Celebrex met the same end points as Vioxx did against the older NSAIDs, [redacted] Non-Resp. [redacted] Non-Resp.

Celebrex represents a major advance in the treatment of arthritis. It can be used without unnecessary concern in older patients, and can be used appropriately in the more than 40 percent of arthritis patients who also have hypertension. We are quite confident in our product, our data, and in the future. And if there's any further questions about the data I actually might refer you to the publication of the long-term outcomes data in the September of *JAMA* or the pivotal NDA trial against Naproxen, which was also published in *JAMA* in November of '99.

We're delighted with the excellent progress and momentum of Celebrex in Europe. Despite almost a year's head start for Vioxx in many markets, our recent launches have propelled Celebrex to be the number one coxib product in France, Italy, and Spain in sales and units after only three months on the market. In fact, Celebrex is setting a trajectory that already makes it one of the most successful launches ever in the French market. We believe we have delivered the anticipated positive impact of our merger on the performance of Celebrex in Europe.

We're very optimistic about the long-term potential for Celebrex in Europe as we focus on penetration into the NSAID market. The most important growth opportunity for both Europe and the U.S. is to gain and hold market share of the coxib segment while converting the NSAID market.

Turning to the U.S., Celebrex sales increased by 35 percent to $597 million for the quarter. For the year, Celebrex U.S. sales totaled $2.2 billion, up 63 percent. In the U.S., Celebrex is the clear sales leader, and during the past quarter we have significantly slowed Vioxx growth. Our goal now is to maintain our sales leadership position while expanding the use of Celebrex due to its significant benefits over the older, non-selective NSAIDs.

In December, the coxibs accounted for less than half of the total prescriptions in the anti-arthritis and pain market in the U.S., and we believe there's tremendous potential to grow market share by increasing awareness of the distinct benefits of Celebrex versus the traditional, non-selective NSAIDs. Our goal over the next several years is to focus on growing the coxib segment to approximately two-thirds of the total market.

With Celebrex, we were first to introduce this major innovation and we will also be the first to market with another significant advance, a second-generation coxib drug and the first and only injectable parecoxib. Recently presented safety and efficacy data on parecoxib showed it to be superior to morphine four milligrams, with comparable efficacy in longer duration of action compared to the recommended dose of the injectable NSAID cotorolac. Parecoxib does not seem to show the usual injectable analgesic side effects such as respiratory depression, increased bleeding, or CNS toxicity.

The launch of parecoxib will allow us to expand our coxib franchise into a new and under served market, and will complement Celebrex without competing with it.

As Fred mentioned, our second-generation oral product valdecoxib also remains on track.

Xalatan, our growth driver for the treatment of glaucoma continued to perform extremely well in the fourth quarter. It remains the world's top selling branded prescription glaucoma product, with more than 50 million prescriptions written to date. It is currently the most effective product on the market for lowering IOP, requiring only one drop once a day.

Worldwide sales of Xalatan for the fourth quarter were $196 million, an increase of 23 percent over the fourth quarter last year. Annual sales totaled $693 million, a 37 percent increase over 1999. Xalatan's value share has grown to 32 percent globally and to 36 percent in the U.S., where it is by far the number one branded glaucoma treatment, outselling all forms of timolol and exceeding Alphagan sales by a two to one margin. During 2000, Xalatan in the U.S. grew faster than at any time since its initial launch, gaining four total prescription market share points during the year. In 2001 Xalatan may come under increased competitive pressure, but we plan to vigorously defend our intellectual property in this very important area.

Xalatan's growth in Japan has been particularly impressive. In that market, Xalatan has captured the number one spot from timolol in just 21 months and has overtaken the beta blocker medications, the traditional standard, to capture a 25 percent market share, selling more than $100 million in the year 2000.

Xalcom, our new combination product for glaucoma patients who require more aggressive therapy, was approved in Sweden on December 18th. European launches we hope will begin this fall, upon completion of Mutual Recognition. And we continue to work with FDA towards obtaining U.S. approval for Xalcom.

Detrol/Detrusitol, the world's leading brand for overactive bladder achieved global fourth quarter sales of $113 million, a 21 percent increase over the same quarter a year ago. Worldwide sales for the year total $432 million, a 31 percent increase over 1999. And we're pleased to note that sales for the full year in Europe approached the $100 million mark.

Detrol sales in the U.S. totaled $84 million for the quarter, up 20 percent over Q4 1999, and annual U.S. sales were $324 million, up 27 percent over last year. Detrol continues to grow faster than the market in the U.S. in both new prescriptions and total prescriptions, with fourth

quarter new Rx growth up two share points over the same period last year. This is almost double the market growth rate of five percent.

With the December approval of Detrol LA, our new once-daily sustained release product for overactive bladder, the best product on the market just got better. Detrol LA is not just a line extension of Detrol, but a new brand with an improved clinical profile that is superior to the competition. Detrol LA improves the efficacy of the immediate release form by 18 percent and further reduced the incidence of dry mouth by an additional 23 percent.

In terms of overall adverse events, results in patients receiving Detrol LA and placebo were comparable. In addition, Detrol LA offers the convenience of once a day dosing. Detrol LA was launched in the U.S. last month and had no impact on fourth quarter sales. We're pleased to report that, in only three weeks on the market, Detrol LA has already captured a nine percent share of new prescriptions, boosting our share of the OAB market to over 50 percent. We expect Detrol LA to accelerate our already strong growth rates. European launches are expected in the second half of this year.

Turning to our next growth driver, Camptosar, the new gold standard for the treatment of colorectal cancer, fourth quarter sales were up 40 percent over the same period last year to $116 million. Sales for the year totaled $441 million, a 50 percent increase over 1999. Colorectal cancer remains the second leading cause of cancer death, with an estimated 130,000 new cases each year in the U.S. alone. The treatment for first-line colorectal cancer for which we received FDA approval in April currently is providing the main growth for Camptosar. Camptosar penetration into the pool of first-line patients is already over 50 percent. The drug is also being actively studied in the adjuvant setting as a treatment for earlier stage colorectal cancer immediately following surgery.

The presentation of Camptosar phase three data from Japan has created a growing awareness and interest in the use of the drug in treating small cell lung cancer as a second line therapy. Global clinical trials are underway, and preliminary results have been very encouraging. Camptosar is the star in our oncology franchise and represents the kind of growth and momentum we plan to bring to field of oncology in coming years. We call ourselves the "New Oncology Challenger", and plan to be a major force in oncology.

Zyvox, our revolutionary new antibiotic for the treatment of a wide range of significant Gram-positive infections, also continued to perform well and above the standard for most new hospital products. Sales for the eight months since its launch totaled $48 million, including $18 million in the fourth quarter. It appears that Zyvox is being used appropriately, but early in treatment of seriously ill patients. To date, about 30,000 patients have been treated with Zyvox, and the majority were treated in hospitals while many were able to go home and continue treatment on an outpatient basis. Zyvox offers both IV and oral formulations so it provides an opportunity for early discharge from the hospital.

Seven more countries approved Zyvox in the fourth quarter, including the U.K., which is the Reference Member in the European Union. The launch in the U.K. is now taking place with

good pre-marketing and thought-leader support to position Zyvox for appropriate, but not restricted use. We expect to roll out Zyvox in the EU later this year following the Mutual Recognition Process. Singapore, Brazil, and Chile have also approved the product.

Another recent development you should be aware of is the filing of an NDA for Somavert, a growth hormone receptor antagonist for the treatment of a rare condition called acromegaly, or gigantism, filed by Sensus Drug Development Corporation. There are about 40,000 patients in the U.S., Europe, and Japan suffering from acromegaly. The FDA has granted Somavert Orphan Drug Status and designated it for priority review. Somavert represents an attractive opportunity for us and is a very good strategic fit with our existing Genotropin business.

To sum up, we are very pleased with our results in 2000 and with the progress we've made since our merger. Overall, we believe we are one of the few large pharmaceutical companies to maintain robust growth throughout the merger and integration process, and to actually increase market share. Pharmacia has now moved up two positions and ranks ninth in the U.S. in the pharmaceutical sales volume, up from 11th a year ago. As you know, we have met our goal set at the time of the merger to become one of the top 10 companies in our industry.

I'd like now to turn the call over to Hakan Astrom, who will lead our Q&A segment – Hakan.

HAKAN ASTROM: Thank you, Carrie. For the Q&A session, we are joined on line by Dr. Phil Needleman, Chairman of R&D. Operator, we can now start to take the questions, please.

OPERATOR: Thank you. The floor is now open for questions and comments. If you do have a question or a comment, please press the numbers one, followed by four on your touch-tone telephone at this time. If at any point your question has been answered, you may remove yourself from queue by pressing the pound key. Questions will be taken in the order received. We do encourage all participants to please utilize their handset for optimum sound quality.

Please hold as we poll for questions.

Our first question is coming from Mario Corso of ABN AMRO. Please go ahead, sir.

MARIO CORSO, ABN AMRO: Yes. Good afternoon. On the third quarter conference call, an earnings range of $1.75 to $1.80 was given for this year. Can you confirm if that's still the expectation, or if there's deviance from that? And Celebrex was very strong in the fourth quarter internationally. Is that a reasonable run-rate for the product as we head into 2001? Thank you.

HAKAN ASTROM: Chris will take the first question. Can you repeat the second question, please?

MARIO CORSO: Celebrex sales were very strong internationally in the fourth quarter, and I was wondering if this is a reasonable run-rate for 2001?

CHRISTOPHER COUGHLIN: Let me take the first question regarding guidance. I don't recall that we gave a specific range, but we gave a growth rate. And let me say that our guidance has not changed and it's consistent with our prior discussions. As you know, we have said consistently that our goal is a 20 percent compound annual growth target for earnings. We exceeded that, obviously, in 2000 with a growth rate of over 30 percent. So in 2001, we anticipate our earnings growth will be in excess of 20 percent. The dilutive impact of our Ag IPO and the increase in the number of shares will reduce our EPS growth rate below the income growth rate.

As I indicated, we had income from collaboration payments of some $145 million in each of the last two years. Therefore, the base business earnings must increase by over 25 percent to meet these aggressive targets. We're also watching the yen quite closely, as it has weakened over the past few months. We're on track, and we'll be supplying more information in the next couple of weeks which should continue to help tighten this guidance going forward.

HAKAN ASTROM: Carrie take the second question.

CARRIE COX: We are delighted with the momentum that we're building with Celebrex sales in Europe, and are making significant penetration into some of the top markets. In terms of market share now, we are beginning to hold a significant position. I think what you'll see going forward is less ongoing growth in market share, because we've done extremely well, but more of an expansion of the coxib segment of the overall arthritis market.

We'll hold a strong leadership position, which we believe will continue to grow in Europe, but the future really is going to be in converting the older NSAID business across Europe into Celebrex business.

HAKAN ASTROM: Thank you, Carrie. We can take the next question, please.

OPERATOR: Our next question is coming from Jami Rubin of Morgan Stanley Dean Witter. Please go ahead.

JAMI RUBIN, MORGAN STANLEY DEAN WITTER: Thank you. I actually have two questions for Carrie. Carrie, the first question is on Celebrex. If the FDA does allow you to add the additional CLASS safety data in the label, what does that mean in terms of marketing? What can you additionally say in your marketing pitches that you can't say already? My understanding is that this is already in the public domain and you're already utilizing the CLASS data for your marketing pitches.

The second question has to do with the outlook for Xalatan. If Lumigan gets first-line therapy, what does that mean for the outlook of Xalatan? Thanks.

CARRIE COX: In terms of the situation for Celebrex moving forward, the *JAMA* paper, as I mentioned, was published in September, and that contains the results from the long-term outcomes studies. I think we've had a lot of benefit in the marketplace of being able to use the

data. Going forward, the labeling changes are yet to be enacted, so I think it's not appropriate to predict what that might entail. But we do have access to the data and have had for some period of time.

If we look at the Lumigan and Xalatan situations in the future, that's another one where I think the strength of the performance of Xalatan has become very well established in the market. You might recall that, in the U.S., we see over 40 percent of the use of the product is in early disease as monotherapy. It is very well established as an early agent in appropriate patients. I think that there's nothing that can replace that kind of hands-on experience that the doctors have and that patients have.

As you know, we hope to bring Xalcom forward in the future, and that will continue to expand the franchise as we have an even greater use of Xalatan in combination segments of the market. I think we remain in a very strong leadership position with Xalatan.

HAKAN ASTROM: Thank you, Carrie. Is that OK, Jami?

JAMI RUBIN: Oh, yeah. Thank you very much.

HAKAN ASTROM: Next question, please.

OPERATOR: Thank you. Our next question is coming from Mark Striker of Salomon Smith Barney. Please go ahead, sir.

MARK STRIKER, SALOMON SMITH BARNEY: Hi. Thank you. I had two questions on Xalatan. Could you comment a little bit more on your status with the FDA for Xalcom? I see you've gotten the approval in Sweden, which was good news, but you have two approvable letters in the U.S. Will the FDA require more studies there?

Could you also talk a little bit more about your patent – I think it's the Columbia University patent? Do you think that can actually block some of your future competitors from the market in the class? Thank you.

HAKAN ASTROM: Carrie.

CARRIE COX: The Xalcom approvable letter, as you said, has been received from FDA and at this point we do not believe there are additional studies required, but we continue to have discussions with FDA towards approval. And in terms of Xalatan, we remain quite confident in our intellectual property, and as I said, we're going to defend it pretty vigorously.

HAKAN ASTROM: Thanks, Carrie. Could we take the next question, please?

OPERATOR: Thank you. Our next question is coming from Steve Tighe of Merrill Lynch. Please go ahead, sir.

STEVE TIGHE, MERRILL LYNCH: Good morning. I don't want to beat a dead horse, but I just want to make sure that I understand this clearly. In the third quarter press release, it says the company expects EPS to grow 20 percent to 25 percent. In today's press release, it says earnings per share expected to grow approximately 20 percent. Am I supposed to interpret this as nothing more than a change in language, but the same exact outlook that you had in the third quarter?

Moving on to my next question. It looks like there was approximately $80 million in wholesaler stocking for Celebrex in the fourth quarter. I think we were looking at something like $40 to $50 million in the third quarter. Does that add up cumulatively to about $120 million? When do you expect this to come out of the channel. Thank you.

HAKAN ASTROM: This question is for Chris.

CHRISTOPHER COUGHLIN: OK. You may have to repeat the second part of that, Steve. In terms of the guidance, what we're trying to do right now is tighten the guidance a little bit. So our guidance has not changed from what it has been in the past. It's very similar. And again, we're looking out a year, with things like foreign exchange and other non-controllable factors. We're still in that range, and we're still in the range that we put out at the time of the merger. I think as you get more information in the next week or so it will help people with the guidance going forward.

I'm sorry, I missed the second part of your question, Steve.

STEVE TIGHE: It looks like there was approximately $80 million in Celebrex wholesaler stocking in the fourth quarter. And I think we were estimating something like $40 to $50 million in the third quarter. Do you now have a cumulative stocking issue of around $120 million, or is my math wrong on Celebrex? When can we expect that to come back out of the trade?

It seems to me you probably want to get your inventories down to a more normalized level, so that's got to come back out at some point in time.

CHRISTOPHER COUGHLIN: Steve, I think your math is probably pretty close. I mean, I think that we would estimate that across our product lines, we have about $100 million of inventory in the pipeline. We'll see much of that come out in the first quarter. We've explained the reasons why, in both the third and the fourth quarter, there were some pipeline issues. We see a fair amount of that coming out in the first quarter.

STEVE TIGHE: Thanks, Chris.

HAKAN ASTROM: Next question, please.

OPERATOR: Our next question is coming from Barbara Ryan of Deutsche Bank. Please go ahead.

BARBARA RYAN, DEUTSCHE BANK: Good morning. My question is for Carrie. If we can go back to the Celebrex review, having listened to that review in painful detail during the two days, I guess I'm a little confused by your statement. One thing that was discussed, I guess broadly, both days in relation to both studies was that the committee felt that there was an increased trend towards cardiovascular events, which in their view, was equal in size to the trend towards improved GI safety. There was also a discussion that neither study was obviously powered or designed to detect any cardiovascular outcomes. Therefore, the committee felt that they couldn't say.

The committee seemed to agree on language which said that these drugs are not cardio-protective. Therefore, patients at risk for cardiovascular events should be on aspirin, and that aspirin may in fact offset the GI benefits.

Additionally, the committee did discuss, on Thursday afternoon, that Celebrex was better than ibuprofen, but not better than diclofenac. I'm just wondering how you square those statements with the statements you're making relative to Vioxx and cardiovascular risk. I didn't detect any distinction by the committee, at least, it was a COX-2 issue in their opinion.

HAKAN ASTROM: Barbara, I would like Dr. Needleman to respond to this question and if there's anything to add from Carrie, we can see after that. Phil, can you take this question?

Have we lost Phil from the line?

DR. PHIL NEEDLEMAN: Hello? Have you got me?

HAKAN ASTROM: Yes, we can hear you now.

DR. NEEDLEMAN: Hi. I certainly agree about the painful part, to sit there for two days.

Let's go in order. What the committee said about cardiovascular events, and also what they said about GI safety improvement, is that the data warrants inclusion. They gave guidance to the FDA that the data warrants inclusion in the label. If you notice the way an advisory committee works, after the FDA reviewed both documents, they gave guidance to the committee in the form of questions. The Celebrex questions had no cardiovascular issues or events. There was no cardiovascular signal at all, so their questions related to GI. On the second day, questions for Vioxx were largely around the GI events and cardiovascular and thrombotic issues. In fact, there was no signal, no change of signal, nor issue raised by the FDA even in their presentation to the committee that Celebrex has cardiovascular or thrombotic events. The concern of the committee was those that were reported in the Vioxx presentation and they wanted that complete picture to have balance of GI versus cardiovascular.

BARBARA RYAN: On the second day, didn't they also put together a separate discussion which was on COX-2s and this cardiovascular issue?

DR. NEEDLEMAN: Well, now I'll go to the second part. It is certainly true that COX-2 inhibitors, by design, don't inhibit platelets and are not cardio-protective, so people should still take low-dose aspirin. That was the only commonality. There were no increases in myocardial infarctions or angina or anything else with Celebrex, and so their concern was about the Vioxx side effects. The agency will review both drugs separately. And I would anticipate, in both cases, you'll see the GI safety enhancements and then the change in side effects. In fact...

BARBARA RYAN: For both drugs, right?

DR. NEEDLEMAN: For both drugs, but both drugs have individual side effects, so they won't be tarred together with one brush.

Now regarding your question about Celebrex and ibuprofen. It is true that Celebrex didn't hit its primary objective, but as the two days went forward, ultimately the committee gave advice that recognizes the GI superiority of Celebrex, even at four times that OA dose. When you take out the influence of aspirin and use the combined end-points, Celebrex beat both of the NSAIDs, and specifically, very strongly beat ibuprofen. It also beat diclofenac on especially in hematocrit/hemoglobin, which reflects lower GI bleeding.

It had improved GI effects, and it also was better in endoscopy in the NDA. In aggregate of all of the side effects, Celebrex was especially strong on ibuprofen and was selectively strong in diclofenac, so we expect all of that to be reflected in the discussions and negotiations to label.

BARBARA RYAN: Thanks, Dr. Needleman.

DR. NEEDLEMAN: Thank you.

HAKAN ASTROM: Thank you, Phil. Operator, we will take two more questions.

OPERATOR: Our next question is coming from Norman Fidel of Alliance Capital. Please go ahead, sir.

NORMAN FIDEL, ALLIANCE CAPITAL: Yes, thank you. Could I ask you to look at '99, '00, and expectations in '01, and again go over the impact of these milestones and related payments, which I assume are in the Searle wagon, not elsewhere. Can you give us pretax and after-tax impact in '99, '00, and expectations in '01 for these types of items? Thanks.

CHRISTOPHER COUGHLIN: Norman, I'll take that. As I've said, in the last two years. there have been collaboration payments that have been included in our income of $145 million in both 1999 and in 2000. Those will not repeat going forward. There are other milestone payments that we talked about. And again, these all relate to Searle and how they have accounted for these things historically. You will see, going forward, some milestone payments that were taken in income back as early as 1996 that, under SAB101, have to be restated going forward. There is a very immaterial impact of that going forward. $145 million in both '99 and 2000 that do not

repeat. You can use sort of an average tax rate, I think, on those of about 35 percent to get a reasonable estimate.

NORMAN FIDEL: Thank you.

HAKAN ASTROM: Thank you, Chris. The final question, please.

OPERATOR: Our final question is coming from Stephen Wickholm of Oris Mason. Please go ahead, sir.

STEPHEN WICKHOLM, ORIS MASON: Thank you. I have some questions regarding the sales growth. If you look at that you can see that the sales growth is driven by Celebrex and Ambien, but looking at some of the other rather big products, we can see in the figures that the growth is slowing down. The question is, why? Is it the currency effect, because it may be more important in Europe? In that case, what is your assumption for the 2000 year when it comes to currency, when you're talking about double-digit sales growth.

HAKAN ASTROM: Thank you, Stephen. Carrie will answer that question.

CARRIE COX: We have suffered the impact of currency fluctuations across the broad base of sales that are in Europe. The actual local currency and unit sales have been very strong, and we are expecting to see that begin to right itself in the second half of this year.

CHRIS COUGHLIN: And I will also just comment in terms of how does that impact our guidance going forward. We're confident that, at reasonable levels now of the Euro and the yen, that we will still meet that commitment. Again, we have a much larger percentage of our business coming from the U.S. now, where we continue to expect strong growth. So we're confident in that revenue guidance.

STEPHEN WICKHOLM: OK. May I also then ask about Zyvox? How is Zyvox prescribed and used in the hospitals today? Is it used as a last resort product when you cannot treat an infection with something else, or is it used more broadly, as the way you would like to see it be used? As a matter of fact, the sales growth for the product is not that impressive, even if Carrie gave a very positive description of the situation. Is it really living up to your expectations?

HAKAN ASTROM: Carrie will answer the question.

CARRIE COX: Zyvox is, in fact, developing very well in terms of the sales picture for a hospital product, and that's an important thing to note – that this is a product that is really to be used for seriously ill patients in the hospital. However, within that, we are very pleased that the product is being used appropriately and is not being restricted. It's used as it should be, in hospitalized patients, but used early, and not being held for salvage therapy.

We'd like to continue to see more use in patients who might otherwise get vancomycin, so there's still significant room for growth. The trajectory that's been established in the first eight months

in the U.S. market is very good, and in fact, better than most hospital products where there's typically a much slower uptake. We are launching now in February in the U.K. The label there is fairly strong, and our expectation is that we'll be able to have appropriate use and not have Zyvox saved for salvage use. That is simply not the best way to help patients and maximize the product.

STEPHEN WICKHOLM: Thank you very much.

HAKAN ASTROM: Thank you, Carrie. And that concludes our Q&A session, and I'll turn the call back over to Fred Hassan for some final remarks.

FRED HASSAN: Thank you, Hakan, and thanks to you all of you for the opportunity to respond to your questions. Let me make just a few concluding comments. As we look at our results for 2000, we really feel gratified that we've not only produced exceptional results, we've also done our merger right. We've created a unified motivated organization, and we have a powerful product portfolio and an exciting pipeline of new innovation. We have the strength we need to compete as a top tier player on a global basis. Most importantly of all, we are creating a culture and work processes that we are convinced will give us a competitive edge. We have a unique combination of assets and dynamism in Pharmacia, and we're also uniquely positioned to meet the new challenges our industry will face. Again, thank you for joining us today. Goodbye.

OPERATOR: Thank you. This concludes today's teleconference. Have a wonderful day.

EXHIBIT 170

From: Weiner, Ethan
Sent: Monday, August 20, 2001 12:21 PM
To: Shafner, Lori S; Fletcher, Mark P; Gandelman, Mitchell; Kitsis, Elizabeth; Crosbie-Foote, Holly; Gavigan, Michael; Sirota, Eric
Cc: Finman, Jeffrey; Ting, Naitee; Loose, Leland D; Cristo, Stephen; Wahba, Mona M
Subject: RE: JAMA response

Sensitivity: Confidential

As stated in my comments, I think the letter should also talk alittle about process, not just the data. The process was that six month data were deemed best due to informative censoring (as expressed). Therefore, the six month analysis was shared with FDA and others as well as used for the manuscript. FDA preferred the 12 month analysis despite informative sensoring and so that is what was discussed at the advisory committee. This does not mean the six month analysis was wrong, as the authors of the letter to the editor implied. More importantly, it shows that we did not use one analysis for publication, another for FDA. Had the reviewers for JAMA agreed with FDA regarding 6 and 12 month analyses, they would have requested the change as well from one to the other. I think the letter needs to stress this as much as the data. Right now the response mentions it, but the message I get is "we used six month in the journal publication and it really isn't different from the 12 month data FDA used in their analysis". That's fine for step 1, but step 2 is that we need also to give the message "we feel the six month analysis is more valid. This is the analysis we sent to FDA as well as was used for the JAMA article. FDA preferred the 12 month analysis and we provided it for them. JAMA stuck with the 6 month analysis". Without step 2, the reader will still assume that somehow we selectively sent one analysis to JAMA and another to FDA and this is NOT the case.

-----Original Message-----
From: Shafner, Lori S
Sent: Sunday, August 19, 2001 7:59 PM
To: Fletcher, Mark P; Weiner, Ethan; Gandelman, Mitchell; Kitsis, Elizabeth; Crosbie-Foote, Holly; Gavigan, Michael; Sirota, Eric
Cc: Finman, Jeffrey; Ting, Naitee; Loose, Leland D; Cristo, Stephen; Wahba, Mona M
Subject: RE: JAMA response
Sensitivity: Confidential

Dear all,

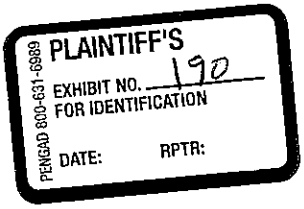
I will leave comments on the technical merits of the response letter to the experts. However, I would offer the general comment that the tone of the draft response is a bit harsh/tense and leaves the reader feeling alienated instead of convinced.

Point #7 should be removed as it is not relevant to the key arguments.

Additionally, the last paragraph should be expanded to specify why Dr. Wright's comments are inaccurate instead of referring the reader to transcripts which take days to review.

Lori

-----Original Message-----
From: Fletcher, Mark P



Sent: Friday, August 17, 2001 2:47 PM
To: Weiner, Ethan; Gandelman, Mitchell; Kitsis, Elizabeth; Crosbie-Foote, Holly; Gavigan, Michael; Sirota, Eric
Cc: Finman, Jeffrey; Ting, Naitee; Loose, Leland D; Cristo, Stephen; Wahba, Mona M; Shafner, Lori S
Subject: FW: JAMA response
Importance: High
Sensitivity: Confidential

Ethan,Mitch, and Liz

After hearing some indirect rumors from PHA R&D people over the last week re: a JAMA article issue but them not sharing anything with me (thought it was related to the Washington Post article last week with focus on role of Pharma on peer-reviwed manuscripts, etc.)I received a call from Ken Verburg midday today indicating the following:

PHA had received 2 letters to the editor from JAMA re: concern about the JAMA CLASS article not correctly or fully representing the data (as found on the FDA Web site) and asking for corrective action and how this happended, etc.

PHA R&D has apparently been crafting a response (many drafts- none ever sent to us or even let me know what was happening until now) and wants me to review this and OK it by the end of the day today.

Told him that I found this situation very unfortunate and upsetting that they haven't shared any of this (especially early drafts of responses) with us until the 11th hour.

Is this one of the issues you have been working on the past few days or is it another?

Please let me know ASAP and advise one way or the other. Unless I hear otherwise, I am going to tell Ken that I cannot agree to sending this in until Pfizer can review it appropirately- would shoot for EOB by Monday, but will know better by Monday AM.

Call me at 203-291-5762 today or over the weekend.

Mark P. Fletcher, MD
Global Clinical Leader, COX-2 Alliance
Pfizer Global Research and Development
Groton, CT
(W) 860-715-0246
(Priv) 860-715-4828
(Fax) 860-441-3219
(TopCall): 860-715-8479
(Mobil): 860-625-9250
e-mail: mark_p_fletcher@groton. pfizer.com

-----Original Message-----
From: VERBURG, KENNETH M [R&D/1820]
[mailto:kenneth.m.verburg@pharmacia.com]
Sent: Friday, August 17, 2001 1:31 PM
To: Fletcher, Mark P
Subject: JAMA response

Mark-
here you go.
Ken

<<hrachovec.doc>> <<jmwright.doc>> <<JAMA responses to letters to the editor 08-17-01.doc>>